The Lumleian Lectures

ON

THE DIAGNOSIS, PROGNOSIS, AND PROPHYLAXIS OF INSANITY.

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LECTURE II.

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THE PROGNOSIS OF INSANITY.

MR. PRESIDENT AND GENTLEMEN,—I have said that in many cases of insanity the diagnosis is doubtful and hazardous. When we proceed to consider the prognosis we find that our difficulties are not diminished, but if anything are increased. For the purposes of diagnosis we have to examine the state of mind of the individual at the time we see him; but to form a prognosis we have to look into the future, and to say what will happen to a patient under all circumstances—circumstances over which we may have no control, and treatment or want of treatment with which we have nothing to do. The physician called to a case of ordinary illness receives a coherent and true account of the symptoms, past and present, from the sick man and his friends or nurse. He is generally enabled by what he hears and sees to form an accurate diagnosis of the malady, and his knowledge and experience enable him to give a confident prognosis of the result, knowing well that all will be done for the sufferer that can be done, that his directions will be strictly adhered to, and that the patient himself will second his efforts and try to get well. Contrast this with a case of insanity. The patient is excited and exalted. He denies that there is anything the matter with him, scoffs at physicians and at the notion that he requires one, says he was never better in his life, and will have none of medical treatment unless it is compulsory. Or he is not exalted, but depressed; then he thinks that a physician can do him no good, that he is very wicked—too wicked to live—that his immortal soul is for ever lost, and if anyone is to do him good it is the parson and not the medical man. Another is suspicious and thinks there is a conspiracy to poison or ruin him; he is very shy of a strange medical man or of his own if he includes him in the plot, and completely refuses to take his advice. When we ask for information from the friends, what do we get? They will minimise the symptoms as far as they can; will say they have lasted a week when they have lasted for months; and all that we hear we have to look upon as doubtful and untrustworthy. When we tell them that the patient is insane we are immediately asked, How long will the insanity last, and will he recover? If told that the disorder is curable, but to effect a cure it is absolutely necessary to place the patient at once under proper restraint or in an asylum, they straightway vow that they will not hear of such a thing, that restraint means application to a magistrate and certificates and consequent publicity, and an asylum will stamp him as a lunatic, will interfere with his subsequent career, and prevent his daughters from getting married. In the face of all this we have to pronounce a prognosis upon the case, and this can only be done with a considerable reservation. In many cases, however, it is easy enough, and in these our prognosis will be unfavourable. If our diagnosis leaves no doubt about the nature of the disease, if we are sure that the patient is the victim of general paralysis, we may affirm without hesitation that he will not recover, but will die at no distant date; this verdict will often be received with incredulity by those who see a fine and apparently healthy man before them. The question of time is of great assistance to us, but is one whereon we are dependent on others for information. If we hear that a patient has been insane, and has manifested delusions or hallucinations for upwards of a twelvemonth, our prognosis will be unfavourable, and if they have existed, not for a twelvemonth, but for two, three, or four years, it will be very unfavourable except in certain cases which I shall mention later. We may consider insane patients according to the various methods of classification which writers have put forward. As simple as any will be that according to the various periods of life from childhood to old age. According to this we shall pass in review patients who have inherited the malady, these being chiefly the young, others older persons who have acquired it through the dangers and ills of life. Some owe it to that change we call the climacteric, others to old age.

If we examine the insanity of children below the age of puberty, what do we find? Such insanity is rare. I put aside idiocy and the various phases of the weak-minded or imbecile children, also epilepsy or degenerative cerebral disease, the result of syphilis or injury. Children of unstable nerve-centres occasionally show symptoms of insanity at an early age, and I believe it is always inherited. It may be transient, occurring in the night, taking the form of delirium or night horrors. I have known it to be genuine melancholia, the child being much depressed, sitting alone in the dark, avoiding the society of her brothers and sisters. Yet it all passed away in a short time by removal from home and the companionship of other lively children. The prognosis here is good, but it indicates a neurotic condition which should not be overlooked. Then we come to the period of puberty, a time of profound physiological change, of great importance, not only to the female, but also to the male. There is now not only a development of the body and its functions, the procreative system, the osseous and muscular, but also of the brain-centres and mind. It might be supposed that at this time of change insanity would be frequent. It is not, however. As years advance the number of cases increases. In the Commissioners' Report for 1894 we read that during the five years, 1888 to 1892 inclusive, the yearly average of patients admitted under the age of fifteen was 323. Those between the ages of fifteen and nineteen averaged 835, while those between twenty and twenty-four were 1520. These latter are the adolescents, suffering from what has been termed the insanity of adolescence, and the prognosis in this and the insanity of puberty is equally favourable—at any rate in the females. Its character is almost always mania with excitement, exaltation, hilarious and noisy chattering and restless movement. Mr. Bevan Lewis says that, "of all the types of insanity, that occurring at the puerperal period is one of the most recoverable, yet the recovery rate is nearly as high for the insanity incidental to adolescence." And he gives the recovery rate in puerperal cases at 80 per cent., while that of adolescent females is 73·3 per cent. But, he says, "it is far otherwise with the same affection amongst men; in them, where depression is often largely present, the prognosis is far less favourable, and a wide margin must be allowed for partial recoveries, chronic incurables, and fatal cases." And he gives the recovery rate of adolescent males as 58·4 per cent. My own experience agrees with this. I have found a much larger proportion of young men remaining as a chronic residuum in asylums than of young women, and the majority of the former were patients whose insanity was melancholia, and not the noisy mania which is the characteristic form amongst the young. It would seem that the prognosis is unfavourable where the insanity does not present the characteristics which should belong to the time of life. The young when melancholic do not recover rapidly, while of acute mania at the climacteric the prognosis is bad. There is one form, however, which occurs in the young which is one of apparent depression. This has been called "acute dementia," or "acute primary dementia," or "stupor with dementia," and has been confounded with the stupor of melancholia—*melancholia cum stupore*. It is not the same; it occurs in the young, its onset is rapid, the reduction is great. We never find so rapid a reduction in melancholia. The patient appears to be in a state of fatuous imbecility, lost, dribbling, and dirty, grinning idiotically or sunk in vacuous stupor. Yet the history may enable us to give a favourable prognosis. If we find that this all came on rapidly after some shock or fright, and we can ascertain beyond a doubt that it is not secondary dementia following an attack of acute insanity, and is not a state into which the patient has gradually drifted through hereditary weakness combined with masturbation, we may pronounce hopefully as to the result even in the face of the unfavourable symptoms. The physical condition of these young people is so low that they require special treatment, warmth, food, and nursing; but with this improvement

takes place slowly but surely, and in my experience the improvement has almost always terminated in recovery.

Passing from the insanity of the young, the adolescents below the age of twenty-five, I may fitly consider that of the women, mostly young, who show symptoms of mental disorder before or after childbirth, or during the period of lactation, this being termed the insanity of pregnancy, puerperal insanity, and the insanity of lactation. All writers are agreed that the first is rare. Such cases as occur are seen by the family rather than the asylum physician, and but few are admitted into asylums. Mr. Bevan Lewis says that among 1814 females admitted only eleven cases of insanity during gestation occurred. Of these, nine had previously borne children, and no one had suffered from a previous attack of insanity. Two left the asylum recovered before their confinement, and the recoveries were in the ratio of 54·5 per cent.; two left relieved and two died, one of puerperal fever and the other of chronic phthisis. Dr. Clouston admitted fifteen in nine years to the Royal Edinburgh Asylum, and of these nine recovered, or 60 per cent. of the whole. Nine were of an acute type, seven being suicidal—a large proportion. Seven of the fifteen cases were first pregnancies and five had illegitimate children. Besides the nine who recovered, two were removed and probably got well, and two died—one from uræmic poisoning, the other from general tuberculosis. Dr. Clouston says that this form of disease in its worse forms is more incurable than the insanities of childbed and nursing. In my own experience the cases have not been severe, and, so far as I know, all have recovered. The form has always been melancholia, but not of an acute type. In mild cases the prognosis is good; but of such as are severe enough to require asylum treatment the outlook is not so favourable, and almost all are desperately suicidal. This brings me to the insanity which, albeit acute, is the most curable of all—the insanity of the puerperal period. In the majority of cases the form that this assumes is that of mania, which may rise from quiet and simple mania, with delusions, to very acute delirium. It is readily to be understood that at such a time as parturition the nerve-centres are in a very unstable condition and are ready to explode in extreme excitability. A woman, nervous by constitution and heredity, has been for nine months looking forward to and, perhaps, dreading the event. After labour, which may or may not have been easy, she is subject to the dangers of hæmorrhage, of septic contamination, and all that is attendant on uterine involution. The first thing to be noticed is loss of sleep. This is so important that I mention it here, though it belongs to the treatment rather than the prognosis. I constantly find on inquiring that the patient has slept badly ever since delivery took place. Nurses are frequently less careful than they should be as to this. They may even disturb the patient on behalf of the child, or to give food, make up the fire, or the like. They do not report to the medical attendant the little sleep the patient is having, and in a week, perhaps, mental symptoms appear, sleep is less and less or is altogether lost, and in a few days the patient is in a state of acute or subacute mania. Now if we are called to a case in this state and asked what our prognosis is, the first point to be considered is, Where is this maniacal woman going to be treated? Many such are treated at home, and it is a great thing to be able to save a young mother with, perhaps, her first child from going to an asylum. But if her friends are not able to provide the necessary nurses and medical treatment, if the sufferer is to be kept in a little stuffy room with the sun blazing into it in the dog-days, and perhaps the roar of street traffic outside, to an asylum she ought to go, and if the friends will not consent our prognosis should be a very guarded one. If everything is favourable and the patient is well cared for and has plenty of nourishment—given, if necessary, by forcible feeding—our prognosis will be good. But there are certain points to be considered. First, the age: young women recover better than those more advanced in life—e.g., those who are past the age of thirty; child-bearing in women past the age of thirty with strong hereditary tendency is certainly attended with much risk. Then will come the question of temperature. A high temperature in all acute insanity is very unfavourable, and here is especially so; for it may depend either on mere maniacal excitement or on some febrile condition of blood-poisoning, and we may have to treat not only puerperal mania, but also puerperal fever. Dr. Clouston gives us the particulars of 60 cases admitted in the Royal Edinburgh Asylum, and of these 5 died all within two months, 4 within one month, and in all that died the temperature was over 100° F. Yet of 5 cases in which it was over 103° 3 made excellent recoveries. Mr. Bevan Lewis gives us the particulars of 68 cases, and here the mortality was 6. The mortality of Dr. Clouston's cases was 8·3 per cent., that of Mr. Lewis's 8·5 per cent. These two ratios are nearly identical, and are probably the correct proportion of deaths from the disorder. The recoveries also as reported by these two gentlemen are nearly the same. Of Dr. Clouston's the ratio was 75 per cent., of Mr. Bevan Lewis's 80 per cent. This, I need not say, is a high rate of recovery, the highest of all forms of insanity, and the reason for its being so high is not hard to discover. Such cases are all acute, most of them commencing in the first fortnight after delivery. This being the case, the patients are under medical observation and nursing, and if they are mild cases they are treated promptly and efficiently at home, or, if they are too severe for home treatment, they are at once removed to an asylum, where, with suitable care and constant feeding, they recover rapidly and surely. They do not drift on without treatment, as so many ordinary maniacal and melancholic patients do. The value of early treatment is well illustrated by these puerperal cases, even in the patients sent to asylums. These are Mr. Bevan Lewis's words: "The incalculable advantage of early treatment is very obvious in the recovery list, since of four-and-twenty who were placed in the asylum within one week of the onset of their insanity as many as thirteen were recovered within three months and the remaining eleven left recovered within five months, and this despite the fact that several of these patients had inherited strong neurotic tendencies." He tells us also that those who remained as chronic insane or who succumbed to a fatal malady were either late admissions or women over thirty years of age.

From the insanity following parturition we pass to that which occurs during the period of lactation. This may arise in two ways. It may come on at an early date after childbirth, in the fifth or sixth month, and may be due to defective uterine involution, to reflex irritation and excitement arising from suckling, or to disturbed sleep or lactation undertaken in the face of bodily illness, or it may appear later as the result of exhausting and long-continued suckling. It is not uncommon to find women nursing for months, even after cerebral disturbance has developed. Such cases occur most frequently amongst the poor and are admitted to public asylums. Yet of these the prognosis is favourable, especially of those whose insanity appears at an early date after delivery. Of Dr. Clouston's cases the recovery rate was higher than that of the puerperal, and Mr. Bevan Lewis gives one of 65·6 per cent. I myself have seen but little of the insanity of lactation in private practice, and Dr. Clouston says that of 166 ladies admitted only two were lactational cases, though there were among them the usual proportion of puerperal.

We have now arrived at the period of adult life, the period of from twenty-five years to forty-five, a period which will include many of the puerperal cases I have just been speaking of, and the largest number of patients of all kinds, for in the Commissioners' last report the average number of admissions of persons between these ages was 7·310 out of a total of all ages of 16 045. A large number of them will be found to be cases of mania, the majority of those suffering from general paralysis will also be included, and a certain proportion will be melancholic. I shall proceed to consider the cases of mania first. Under this term are comprised all the various states of exaltation, which range from a slight reduction of control to one of delusion or hallucination, and thence to a condition of maniacal delirium of the gravest nature. Now, although the last is a condition of most profound reduction, and clinically becomes a malady of the most formidable character, yet there is no absolute line of demarcation between acute mania and acute delirious mania, the latter differing from the former in intensity. The prognosis, however, will differ widely. In delirious mania the first question is, Will the patient live out the storm or die? We may prophesy that if he or she lives recovery will take place unless certain circumstances are unfavourable. In answer to the question, it may be said that young persons, and especially women, almost always recover, at any rate in the first attack. Women seem to withstand the strain of excitement and want of sleep much better than men. This will account for the large number of recoveries from puerperal mania, and the proportion of recoveries from delirious mania is, in my experience, quite as large. In thirty-six years I have lost only one young female patient from

acute delirium under asylum treatment. This one died, in my opinion, from opium poisoning, the result of hypodermic injections of morphia given, but not by my advice, at the time when these injections were first practised and were greatly in vogue. Our prognosis, then, will be favourable if the patient is properly placed for suitable treatment, if rooms and attendants are adequate, and if the latter know their business. Much depends on the patient being properly nourished, and the feeding is a matter for skilled attendants, and for them only. We do not find food obstinately resisted as in melancholia, but amateurs are not likely to succeed in giving it or in giving a sufficient quantity. There are various things to be observed before we pronounce our prognosis. The first is the pulse. If this is very quick, even when the patient is comparatively quiet, it is a bad omen. If between the paroxysms of excitement—and this is paroxysmal and periodical in almost every case—the pulse falls to a frequency not much beyond the normal we may be reassured. The tongue, too, tells its tale. Incessant shouting and talking, and the nervous excitement of the disorder, will cover the tongue with a thick, sticky coat of dead epithelium. If it increases and proceeds from yellow to brown, and brown to black, and the lips and teeth are covered with sordes, I need not say that the prognosis is bad; but nowadays, when we do not give opium and sleep is produced by drugs like chloral, chloralamide, and the bromides, this typhoid-like tongue is less often seen. Women, too, will go through a period of the most acute delirium and keep a clean tongue throughout. Then there is the temperature. It is wonderful how in many of the most delirious cases, with never-ceasing muscular movement and violence, the temperature will remain only a very little raised above the normal at 99° or 99·5°. We may find it rise to 100°, and yet not be alarmed, but if it goes beyond 100° and rises to 102° or 103° the prognosis is bad, and the patient's life is in danger. There is an acute mania where there is no delirium. Acute delirious mania runs a rapid course of a few weeks, terminating in death or, in the majority of cases, in recovery, while the noisy, garrulous, exalted state of acute mania may last for six months, a year, or even longer, and then pass away and sanity return. The prognosis points to a different issue. It is not a question of life or death; we are not anxious about the lives of these patients. The important point is, Will they recover their reason or not? Sometimes we see noisy mania varying from silly and frivolous hilarity to anger and abuse, yet without delusion, an absolute want of self-control constituting that moral insanity I have already spoken of. We inquire the duration of the attack, the history of previous attacks, if any, the condition of the patient during the interval between the attacks, the health and bodily strength, the probable cause, and the family history. The more recent the attack and the more rapid the onset the better the prognosis. If it is one of a long series of attacks and has lasted for months, we may have doubts, though sometimes patients have such attacks recurring at intervals through a long life.

The cases of simple mania with excitement are not nearly so numerous as those with delusions and hallucinations. How will our prognosis be affected by these? Delusions are no doubt evidence of a considerable reduction in the healthy action of the brain-centres. They are generally the outcome of a somewhat acute attack of insanity. If the symptoms of the latter are present, the attack having begun recently, the fact of there being delusions need not make us give an unfavourable prognosis. The attack subsides, the delusions vanish, and the patient recovers. It is wonderful how delusions vanish which have been persistently adhered to for some time. In some cases the delusions are perpetually changing. To-day there is one fancy, to-morrow another. This is a good sign. It sometimes happens, however, that all the acute symptoms subside, the patient recovers his sleep, and is able to occupy and amuse himself, but some one delusion remains obstinately fixed and becomes organised in the brain. If this goes on for any length of time, for a year or more, the individual not being melancholic, the prognosis is bad. The nature of chronic delusions varies considerably, and I am not aware that one class is more persistent than another. I have found hypochondriacal fancies very difficult to eradicate, but these are the outcome of melancholia rather than mania, and some will retain delusions of grandeur. There are in most asylums chronic patients who think themselves kings or queens, or dukes or duchesses, and will sign themselves by imaginary titles in their letters. Of course, I am not now speaking of the exalted delusions of the general paralytic. Whenever we find these ideas of grandeur we suspect general paralysis, and then arises the question of diagnosis. If we can establish the fact that the patient is suffering from this fatal disorder beyond any doubt the prognosis follows. But occasionally the diagnosis is extremely difficult, and sometimes the most unlikely cases recover and *vice versâ*.

How do hallucinations affect our prognosis? We find hallucinations of all the senses, but chiefly of sight and hearing. In an acute state of insanity hallucinations of sight are very common. Patients see visions, faces of angels, faces of devils, animals, birds, snakes, and the like, as do those who are suffering from the acute alcoholic insanity which we call delirium tremens. In the acute state other hallucinations occur also, as those of hearing, taste, and smell, or the muscular sense. But none of these need render our prognosis unfavourable. They come and they go; when the acute stage has passed away they vanish, very frequently before the delusions which accompany them. It is quite otherwise, however, with hallucinations found in non-acute or chronic cases. They are almost always those of hearing, and generally take the form of voices speaking from the next room or the next house by means of wires or telephones or some supernatural agency. If a patient who has apparently recovered from the acute state and is in all other respects restored to mental health still hears voices—not mere sounds, but words and sentences—plain and distinct, the prognosis is decidedly bad. Some lose them even after a considerable period, but these are the exceptions; and in some they vanish for a time, and then upon any failure of health return, to vanish again when the health is improved. Such patients are prone to relapses, and the prognosis is bad, for they are unstable, and there seems to be a weakness of the supreme centres which are constantly losing control.

We come now to another of the epochs of life, that known as the climacteric, an epoch of transformation when various important functions of the body with their corresponding nerve organisations come to an end, sometimes quite suddenly. When we consider what all this involves, it is not surprising that we find it to be eminently a period of nerve instability, when the various chances and accidents of life may exercise an undue influence over the nervous system, and bring about an overthrow of the mental balance. The climacteric and the cessation of the menstrual function are put down as causes of insanity. It would be more correct to say that the whole climacteric period is one of instability in which other causes, moral or physical, exercise a power which would have been resisted at another time and would have passed by without serious harm. In some cases the charge of life will by itself produce mental disorder in persons prone by inheritance, or in those who have no object or aim in life, no occupation, duties, or work. What is the prognosis in these cases? The form of insanity incidental to this period of life is melancholia, more or less acute. It is an opinion common to many that the religious melancholia of this time is peculiarly hopeless and that few recover; but this is not so. The melancholia of women is almost always religious, but many recover. Comparing the statistics of various writers, we may reckon upon 50 per cent. of recoveries. In forming our prognosis we take into consideration the duration of the illness, the question of early treatment, the number of previous attacks, the health of the patient, and the cause, such as alcoholic indulgence. Many recover, but such disorder is far slower in its progress to recovery than the maniacal seizures of earlier life. There is a popular notion that the climacteric change of life will bring relief or even cure to those who are already disordered in mind, or have suffered from periodic attacks, which, it is hoped, will disappear after the new lease of life is taken up. I fear such hopes are doomed to disappointment. In my experience all such patients are not better, but worse, at the time of the cessation of menstruation, and I cannot see how such an important change and the disturbance of such functions can have a beneficial effect on an unstable nervous system. Do we find this insanity in men, and can they be said to undergo a climacteric? Assuredly there is no such functional revolution in them as in women, but they exhibit the same symptoms of mental disorder, though at a later period of life. We should fix the age at sixty-five, which corresponds to the woman's change at fifty. The mental disorder is for the most part melancholia, acute maniacal symptoms being the exception. This brings me to the consideration of melancholia in its varied aspects,

ranging from what is called *simple* melancholia characterised by depressed feeling, inability to apply to work or business or to concentrate thought, but without delusion or hallucination of any kind. The prognosis with regard to this simple melancholia is good. It may last a considerable time and pass away, leaving the patient perfectly sane and sound. There is, no doubt, at the first onset a certain risk of suicide. This is more likely to occur early than late, and should not be lost sight of. Many have these slight attacks periodically, and pass through them even without leaving home and with little medical treatment. I have often tried to cut them short by attacking that much abused organ, the liver, by giving sedatives to improve the sleep, or tonics, but seldom with much success. The disorder appears to run a certain course and to vanish in about the same time, whatever treatment is tried, or if no treatment is tried. A more advanced stage is melancholia with delusions, a more formidable but not an incurable disorder, and one which demands more active treatment—treatment which for many reasons cannot be carried out in a patient's own house amidst a number of terrified or sympathising relatives. Almost all these melancholics are suicidal; all are to be treated as such, and must be carefully guarded and kept from everything with which they can do harm to themselves. Many of them have to go to an asylum, their means not allowing the expense of taking care of them in a private house with proper attendants and the medical supervision which is requisite. A large number refuse their food and have to be fed by force, and this necessitates removal to an asylum, as such feeding cannot be carried on in a private house without a large staff. If all the proper care and treatment be arranged to our satisfaction, the patient sedulously guarded, well fed and housed, with opportunities for air and exercise, the prognosis will be decidedly favourable. Unless very old or completely broken in health, we may hold out a strong hope of a favourable termination, though the cure may take a long time. These are the cases which are cured after years of depression In a case of mania after a year or eighteen months, the prognosis is very bad and few recover; but in melancholia so slow is the process of building up and repairing the waste of nerve-force that a year does not oblige us to give up hope. For a long time we may see no improvement at all, except perhaps in physical health; then there may be a trifling brightening which the patient will altogether deny or try to conceal, but it will go on, it may be very slowly, with perhaps occasional pauses, or even relapses, so that we must estimate it by months rather than weeks. And at last we are rewarded by recovery, and after perhaps years of gloom the sufferer returns to the full possession of every faculty, of reason, memory, and feeling, for the brain appears to have undergone no organic change. It is sad to read in the paper that this person and that have committed suicide because they were depressed when we know that all, or nearly all, might have been cured were they properly treated and guarded. The patients who suffer from simple melancholia, or from melancholia with delusions and suicidal tendency, rising even to what we may call a subacute stage, recover in large numbers and the prognosis is decidedly favourable. Not so is it in the case of those whose reduction is more severe and in whom the disorder assumes the form of acute delirious melancholia. Such persons are usually very debilitated in the beginning, and the violence of the disorder soon exhausts them. Instead of the quiet state or stupor of ordinary melancholia characterised by passive resistance and inertia we see panic-stricken frenzy and incessant motion. The patient paces the room, jumps up and down from his seat, will not lie in bed, thinks the room is on fire or he himself is going to be burned with the fires of hell. He is constantly trying to put an end to himself, will keep no clothes on, will take no food or medicine, and resists to the uttermost everything that has to be done to and for him. The strength of these people is for the most part failing at the onset and does not hold out long against the tremendous strain of this condition, complicated with want of sleep and the struggle over every dose of medicine and food that has to be given. The prognosis in these extreme cases is as bad as it can be. It sometimes happens that a patient has apparently recovered from an attack of melancholia. He seems quite well, and has returned, or is about to return, to his family and friends. All his gloom has passed away, and we are told that he has not been so well for years. He is in such good spirits, so busy and active so full of energy and enthusiasm. This sounds very satisfactory, but as time goes on the good spirits become abnormal excitement and the energy drifts into active mania, and we have instead of melancholia the alternate state of mania set up, and the patient has to be led through an illness of this kind. The converse also may take place, and an attack of melancholic depression may succeed one of mania. This alternation of mania and melancholia constitutes what I have already spoken of as "alternating insanity." After any attack of mania there may be a stage of depression, just as the majority of such attacks commence with depression; but this is not what I mean. In alternating insanity the patient has a well-defined period of the one form followed by a well-defined period of the other; and when he has recovered from the one, after a shorter or longer interval of convalescence, the other follows and runs its course, the two recurring with the utmost regularity, and alternating each time with almost identical symptoms through the rest of life. The prognosis of a case of this kind is extremely unfavourable. Do what we wish in the way of change, treatment, or removal of every supposed cause, the malady returns with fatal regularity. All periodicity in insanity is unfavourable. I have known patients who had alternate days of depression and excitement. This alternation went on for years with the utmost regularity, so that I could always tell the condition in which I should find the individual by referring to that which existed a week or a month ago. I have known the regularity diminish, the patient passing perhaps two or three days in the same state, but I have never known one recover. This alternating insanity is not quite the same as, though closely allied to, recurring insanity. In the latter the same kind of attack recurs after a varying interval. All insanity is liable to recur. A person who has had one attack may have another, but if the latter takes place after perhaps thirty years of health we do not call it recurring insanity. In the latter the attacks recur in rapid succession, coming on without apparent cause and running a similar course. The prognosis is unfavourable. The patients are for the most part the victims of hereditary transmission and are of middle or advanced age. It may, however, commence early, and be continued through a long life.

I have, so far, considered the various kinds of insanity, mania in different degrees, and likewise melancholia, in the different periods of life from youth to age; but besides the age of the individual and the form of the insanity, there are often other points to be taken into account, and these may have much influence on our prognosis. We may derive information and guidance from a knowledge of the cause of the disorder. For this there may be an assignable reason, a moral cause, as it is called—such as grief, worry, or overwork; or a physical, as influenza, a blow on the head, or alcohol. It may be that no cause can be assigned. In the column of the statutory statement sent with a patient we find the cause returned as "unknown" in a very large number of instances. Such insanity has been termed "idiopathic," and if we translate this into other words it means heredity—hereditary instability—and a proneness to rapid reduction of the supreme centres through some slight cause which escapes notice or would produce no effect on a healthy brain. How is the prognosis affected by our knowledge that the disorder is hereditary? The popular idea is that such insanity is very incurable, but this is not borne out by experience. A vast majority of the cases of insanity occurring in young persons is of this kind—cases of the mania of adolescence and of puerperal mania. Parturition is not a frequent cause of insanity when we consider the number of births that take place every year. Women have children, many have large families, with no signs of insanity, therefore those who break down must have inherited an unstable organisation. Yet I have said that puerperal mania is a curable disorder, and according to the statistics a larger number recover from this than from any other form. I have found that those who are affected by inherited insanity recover, at any rate from the first attack, quite as often as others. Being unstable by nature and constitution, they are thrown off their balance by something which in others we should consider trifling, but which is sufficient to cause a reduction of their nerve centres. The reduction, however, is not deep, and recovery takes place. It is clear that such persons are liable to a return of the disorder, which any cause, slight or severe, may bring about; but in the first and possibly subsequent attacks the prognosis is good.

Passing from the hereditary or idiopathic insanity to that which is acquired by the individual himself, we have to consider, first, the "moral causes," so called. These are given in the Commissioners' Report as six varieties: (1) domestic trouble,

including loss of relatives and friends; (2) adverse circumstances, including business anxieties and pecuniary difficulties; (3) mental anxiety and "worry" (not included under the above), and overwork; (4) religious excitement; (5) love affairs, including seduction; and (6) fright and nervous shock. Now these are all called "moral causes," but some of them deserve the name of physical as much as any. The long-continued strain of the first three, which may be comprised in two words—worry or overwork,—must produce a physical effect on the brain cells and brain circulation. You will remember the experiments of Dr. Hodge and his observations on the effect of normal fatigue on the sparrow, the pigeon, the swallow, and the honey-bee. He found that the normal fatigue of the day's exercise caused a marked decrease of the nucleus of the nerve cell, and a jagged and irregular instead of a smooth and rounded outline. This was restored by the night's rest. In man excessive stimulation in the shape of overwork or worry causes a want of control of the vaso-motor system, hyperæmia, over-action of the lower centres owing to obstruction of the higher, deposits of waste, and so on. These are physical effects, though they proceed from moral causes.[1] How does all this affect our prognosis? In proportion to the time that the excessive stimulation has lasted, so will our prognosis be unfavourable or the reverse. Long protracted overwork or worry may produce the same injurious effects on the brain cells and centres as a blow or alcohol. Therefore the duration must affect our verdict. Such acquired insanity must be looked upon very unfavourably. Causes such as the sudden loss of a friend, or a fright or shock, are likely to upset an unstable mind, and to produce a rapid reduction of the mental balance; but this will not be spread over a long time, and will come nearer to that which we call hereditary insanity, and of this the prognosis is good in a first attack if it occurs in one not broken in health.

Passing to the physical causes given in the Commissioners' Report, we find some which have been already considered—as puberty, pregnancy, parturition, and the change of life. Another group is that of uterine and ovarian disorders. How far do these affect our prognosis? Under the head of uterine disorders we have to consider all the derangements of menstruation which are so commonly met with amongst the insane and are so often assigned as the cause of the mental disturbance. Of these amenorrhœa is the most common. It may occur in the course of an acute attack or have been noticed before any mental symptoms. The patient has declined in health and strength, and as concomitant symptoms the amenorrhœa and mental disorder have appeared. When by dint of rest, feeding, and sleep the bodily condition is brought again to its normal level, the catamenia reappear and the patient becomes sane—but not as cause and effect. The amenorrhœa has not caused the insanity, the restoration has not cured it, both having a more remote origin. So, too, menorrhagia may have reduced the strength and insanity has followed. If the menorrhagia is stopped the patient may recover. Neither of these conditions need make us give an unfavourable prognosis. That affections of the uterus, such as displacements, prolapse, and the like, may by a reflex irritation upset an unstable brain is evidenced by many recorded cases, and cures have followed when the uterine disorder has been remedied. The prognosis here will depend on the duration of the mental symptoms and the extent to which they have become organised. I have had a patient recover who had a severe prolapsus uteri which could not be dealt with, while another did not recover from whom an irritating pessary was removed, which was supposed to have given rise to the insanity. Though there may be amenorrhœal and dysmenorrhœal trouble in many cases, I do not think the prognosis depends on this, and examination in the case of young unmarried women is likely to do more harm than good. There is a variety of insanity which has received the name of traumatic. By this is meant insanity which is the result of an accident causing a direct blow or injury to the head, or a shock or shake to the body generally without definite harm to the head. In either case we may find insanity rapidly supervening in an acute form as the result of shock, even when the damage done to the head has been slight, and then our prognosis will be favourable if there are no other conditions to prevent recovery. I have known mental symptoms follow falls and blows and patients recover at all ages. In the young it has taken the form of acute primary dementia, and the issue has been recovery. In elderly persons acute mania or acute melancholia has supervened, and recovery here also has followed. Far other, however, is the prognosis in those cases where the advent of the mental malady is slow and insidious, and we find at first a moral insanity, a gradual perversion and alteration of the whole man, the reduction leading to quiet and concealed delusions, or to loss of memory and incipient dementia, or to the boastfulness and other symptoms of general paralysis. All these point to a chronic organic change which the brain is undergoing and we are powerless to arrest. With traumatic insanity is often, but erroneously, coupled that which is said to proceed from "sunstroke." Sunstroke, in the strict sense of the word, rarely, in my experience, produces insanity; but heat, the continual heat of the tropics, especially in unhealthy places, produces a considerable amount. I have seen many from India, Burmah, the Straits Settlements and such climates, both men and women. I have found such patients when removed to a cold climate recover in the large majority of cases; therefore the prognosis is good. But I have come to the conclusion that those who have once broken down and become insane in the tropics ought not to be allowed to return to those climates. If they do they undergo a great risk even under the favourable conditions of hill stations in the hot weather and such-like precautions. It is not the hot days but the hot nights that try the nervous system and cause sleep to be broken and unrefreshing. More like traumatic insanity is that to which we give the name of alcoholic. Very various are the symptoms and phases of this, and the prognosis will vary equally. This is an acquired insanity, the direct result of alcoholic poisoning; but those who have an hereditary predisposition more readily fall victims, and it is not unfrequently hereditary, the same propensity showing itself in successive generations. All the varieties of insanity may be produced by alcohol. We see acute delirium and acute mania exemplified by the symptoms we call delirium tremens. Less acute than this is the insanity with delusions, either maniacal or melancholic, which is due to long-continued drinking. Now, with regard to the acute symptoms you are all familiar with them, and will agree with me that patients as a rule recover, at any rate from the first attack. Many recover again and again, and have such illnesses periodically for many years. From the less acute insanity the majority recover at first if no unfavourable conditions arise. The stoppage of the drinking allows the poison to be eliminated and the mind is restored. If the drinking is more protracted we may find evidence of organic brain change, paralytic symptoms will be noticed and signs of approaching dementia, as loss of memory and childish conversation. This is frequently the way in which the drinking of women terminates. In them delirium tremens rarely occurs, and after years of alcoholisation paralytic symptoms are often the first to be noticed. Here the prognosis is very unfavourable, yet I have known them recover in a most unexpected manner after being admitted in a helpless condition with complete loss of power in the lower extremities; but recovery of all such means a return to their evil habits, and from a second attack they are not likely to emerge. Insanity from other poisons, such as opium, chloral, or bhang, is rarely met with here. Here and there we find mental symptoms, chiefly depression, coming on in persons who are addicted to opium eating, or that which is now the prevalent fashion, hypodermic injection. The prognosis is not favourable. The patient improves when the morphia is withheld or lessened, for it is not always possible to stop it altogether; but I know no habit so difficult to break through, and though many times interrupted the victim goes back to his syringe unless he is in actual confinement. Of insanity from chloral I have had little experience. If it is stopped I should expect recovery, as the habit is not likely to have continued a long time. Insanity from bhang is common enough in the East, but here we do not see it. The patients recover—at any rate in the earlier attacks.

There is an insanity which occurs in epileptic patients which is of a very serious nature and is by no means uncommon. Epilepsy means a discharge of unstable grey matter, which causes mental symptoms ranging from a loss of consciousness of a very brief duration to most acute mania, or, if of long duration and much severity, to complete dementia. There are many epileptics who have fits, not very numerous or frequent, which do not produce insanity, though a certain cloud may remain for a time after an attack. But if the fits are frequent, or occur a number at a time, they

[1] Cf. Dr. Batty Tuke, Morisonian Lecture, Edinburgh Medical Journal, March, 1894.

may be followed by very acute symptoms. These may pass away, and the patient recover; yet the prognosis is unfavourable. Epilepsy in the adult is a very grave disease, of which cures are the exception rather than the rule, and the occurrence of the disease and the resulting insanity tends to that state of hopeless dementia which characterises the chronic epileptics of our asylums. If the prognosis of insanity following epilepsy is unfavourable, the outlook of that which follows apoplexy is still more gloomy. After an apoplectic seizure well-marked symptoms of insanity, mania or melancholia, may appear either at once or after an interval. They may pass away or alternate, mania and melancholia succeeding one another. But if the more prominent features disappear, there will be a weakness of mind and memory tending to the dementia so constantly found; as in all cases of organic mischief in the brain or its vessels the prognosis is unfavourable, especially in the cases of hæmorrhage, where consciousness is more interrupted than where the damage is due to thrombosis. There are many important questions, such as the degree of mind, the capacity and responsibility of the aphasic, but I am not concerned with such at present. More favourable is the prognosis in that insanity which has been termed post-febrile, and arises in the course or towards the decline of acute disorders such as the eruptive fevers, pneumonia or typhoid fever. This is not to be confounded with the ordinary delirium so often seen, and seen when the temperature is at its highest. The insanity I am speaking of has been well described by Dr. Hermann Weber.[2] It does not come on at the height of the fever, but during its decline, when the temperature has fallen, and he says that the commencement in almost every case occurred immediately after waking from sleep. No doubt the brain in these cases becomes deprived of blood to a considerable extent, and on waking delirium takes place in a patient whose centres are unstable. Of this sudden insanity the prognosis is good, and the attack is usually transitory. Where insanity follows a long-continued illness, whether fever or any other exhausting malady, such as influenza, the prognosis is decidedly unfavourable, and will depend on the general health and recuperative power of the individual. I have seen several patients who had had influenza, and who never recovered. There is much difference of opinion as to the relations of syphilis and insanity. Can we speak of a syphilitic insanity? I do not myself think that insanity in the ordinary sense of the word is due to syphilis except when the latter acts as a moral cause. Syphilophobia is not uncommon. Patients who have or have had specific disease become melancholic and are possessed by the one idea that they shall die of it in its most loathsome form. Even those who have had the disease may conceive a delusion that they have it, and point to every little spot and pimple in proof thereof. Syphilis does produce mental defects, but it does so, as Dr. Hughlings Jackson has shown, "by attacking the neuroglia, the fibrous tissue, bloodvessels, lymphatics, membranes, or bony coverings, involving the nerve tissue and its functions secondarily by pressure, so causing irritation, inflammation and ramollissement, or by starvation[3] from deficient blood-supply, causing degeneration and atrophy." The prognosis is most unfavourable in all cases where the brain is so damaged by syphilis, and I have rarely found that antisyphilitic treatment, which nowadays is so largely used, has produced any beneficial result. There is a form of insanity which has received the name of the insanity of masturbation on which a word or two may be said. Masturbation is very common amongst the insane, common amongst males, and also among females, though perhaps in a less degree. Amongst the latter it is constantly found in an acute attack of mania, but it disappears when the acute symptoms are over. It is not to be supposed, however, that this evil habit is the cause of the insanity in every case where it exists. In many, I may say the majority, it is a symptom. In some neurotic persons with an inherited unstable organisation it may be a cause. Loss of control allows the habit to be indulged in to excess, and the irritation and exhaustion of this perpetual indulgence upsets the weak brain and produces the mental phenomena which have been described as characteristic of this variety. These are morbid and exaggerated ideas of self, sometimes self-importance and conceit, sometimes hypochondriacal fancies about health or delusions that the patient is not sufficiently valued by his relatives and friends. At some time or other there will be an acute or subacute attack of mania or melancholia, and when this passes away there may be a period of remission and an apparent recovery, but the patient soon drifts into hopeless dementia. The prognosis in all such cases is extremely unfavourable.

As I began with the insanity of puberty and adolescence, so will I end with that of old age. And by this I do not mean the dementia which is the last scene in the history of many a once great mind. There may be difficulty in determining the extent of this at the commencement; questions of diagnosis and of mental responsibility may arise, but of the prognosis there can be no doubt. But one meets with a certain number of cases of mania and more frequently of melancholia in old people, many of whom recover in a surprising way. The year before last I was asked to see an old lady of seventy-five years whose mental and bodily strength had been failing, as her medical man told me, for six months. She did not know where she was, though she was in her own house where she had lived for many years, and she had all kinds of delusions. Being unmanageable there she was removed to an asylum, and everyone supposed it to be the beginning of the end. She was in a somewhat acute state for some weeks, had hallucinations of sight and many delusions, and then gradually improved, became perfectly clear in her mind and memory, and went home to the old house in less than three months recovered. Dr. Clouston gives the particulars of 203 cases of senile insanity, excluding 101 others which were cases of epilepsy, mania, or dementia of long-standing or climacteric insanity. He says that heredity as a cause was uncommon. The age was from sixty to ninety years, and of these 203 persons 72 were discharged "recovered"—"that is, in all of them their worst mental symptoms disappeared, they passing into normal senility. In many cases they became quite well in an absolute sense." This is in the proportion of 30 per cent., a large number when the time of life is considered. So that our prognosis is not utterly without hope, though it may be doubtful or even unfavourable. It is to be remembered that all Dr. Clouston's patients and my own whom I have mentioned recovered in asylums. I do not think the same results would be attained by any home treatment.

[2] Transactions of the Medical and Chirurgical Society, vol. xlviii.
[3] Dr. Clouston, Clinical Lectures, p. 420.

Three Lectures
UPON THE
TESTES.

Delivered before the Royal College of Surgeons of England on March 25th, 27th, and 29th, 1895,

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LECTURE III.[1]

Delivered on March 29th.

THE RESULTS UPON THE TESTICLE OF LIGATURE OR DIVISION OF THE VAS DEFERENS.

MR. VICE-PRESIDENT AND GENTLEMEN,—Having given in Lectures I. and II. an account of the structure of the testes at different periods of life and the influence they exercise upon the growth and development of the body, and also of the structure of the undescended testis and the function it is capable of performing, it remains for me to relate the results I have obtained from a series of experiments in which the vas deferens was ligated or divided so as to effectually and permanently obliterate its canal. I propose to give, in the first place, a short *résumé* of the work of previous writers upon this subject, then to show the effect of obliteration of the vas deferens upon the testicle of the puppy and upon that of the full-grown dog, and, lastly, to briefly describe a testis from a young man in whom the vas deferens had been in part accidentally removed during an operation on the spermatic cord.

[1] Lectures I. and II. appeared in THE LANCET of March 30th, 1895.

Hunter [2] gives a full description of a case of obliteration of the vas deferens which he met with in his dissections during the year 1775. In this case, the first of its kind ever described, the vas deferens was, in the greater part of its length, converted into an impervious cord of fibrous connective tissue; but the corresponding testicle, though its duct was thus occluded and in great part obliterated, was of natural size and of normal appearance, as may be seen from the drawing which accompanies the description; and from the context there was nothing observable in the internal structure of the testicle to give rise even to a suspicion of there being any morbid changes. This observation and subsequent ones of a like nature induced Sir Astley Cooper, in the year 1823, to perform the following experiment. He said: "I divided the vas deferens [in the dog] upon the one side and the spermatic artery and vein on the other. The testis upon that side on which the artery and vein were divided gangrened and sloughed away. The testis on that side upon which the duct was divided became somewhat larger than natural. I kept the dog for six years; during that time he was twice seen in coitû, but the female did not produce. This was in 1827. In 1829 I killed him and found the vas deferens below the division excessively enlarged, full of semen, and its extremity closed; the upper portion, however, remained pervious from its point of division to its termination in the urethra. A small space was found to exist between the two divided portions."[3] He made the following remark:[4] "The testis does not in general become absorbed when partially diseased, although its functions may be interrupted, even to the complete obstruction of the passage of semen." Even after this confirmation by experiment of an anatomical observation by Hunter doubt still existed as to the accuracy of the statement. Curling in this country, and Gosselin and afterwards Godard in France, conducted a series of experiments on animals and made a post-mortem dissection in man of several instances in which the vas deferens was in part of its length obliterated. In the main their results confirmed those obtained by Cooper, as may be gathered from the following short extracts from their works. Curling concludes thus: "The foregoing cases and experiments show, then, that the testicles may be properly developed though a physical obstacle to the elimination of their secretion is present from birth; and that so long as the testicles exist entire, though to no purpose, the individual acquires and preserves all the marks of the male sex."[5] Gosselin found the same results after excision of a portion of the vas deferens.[6] Godard[7] makes the following remarks: "Ainsi, l'absence congénital du canal excréteur du sperme chez l'homme, et l'excision du même conduit pratiquée sur les animaux, donnent un résultat identique; dans les deux cas, la glande privée de son conduit se développe et fonctionne comme si elle pouvait éliminer le produit de sa sécrétion, et il est vrai que le testicule privé de communication avec les conduits séminifères ne s'atrophie pas et continue à sécréter le sperme." Thus far all the writers upon this subject seem to agree; and the results of their experimental inquiries simply confirm the inferences drawn from dissections in man. More recently, however, Brissaud examined this subject further and performed similar experiments in rabbits (not in dogs and cats, the animals previously used), and subjected each specimen that he obtained to a minute microscopical examination. Having ligatured their vasa deferentia, he divided the rabbits into two sets; the one he kept alone, and the other he placed among a lot of does, in order that the latter set might be subjected to the full influence of sexual excitement which the presence of the does was supposed to bring about. The following is a *résumé* of the results of his experiments.[8] "En résumé, la ligature du canal déférent ne produit de phénomènes analogues à ceux des cirrhoses par l'oblitération que dans l'épididyme. Le corps d'Highmore semble opposer une barrière infranchissable à la propagation du processus inflammatoire vers le testicule. Enfin, dans le testicule lui-même tout se borne à une exagération transitoire du travail spermatogénique, à la suite de laquelle l'organe, sans retourner à l'état embryonnaire, revient à une constitution plus simple, celle de la neutralité fonctionnelle, c'est-à-dire celle qui précède son développement complet ou qui correspond aux intervalles des époques du rut."

[2] Observations on Certain Parts of the Animal Economy, p. 31.
[3] On the Anatomy of the Testis, p. 52. [4] Ibid., p. 52.
[5] Diseases of the Testis, fourth edition, p. 13.
[6] Annales Générales de Médecine, 1863, tome ii., p. 257.
[7] Recherches sur l'Appareil Séminal de l'Homme, p. 103. Archives de Physiologie Normale et Pathologie, 1880, p. 769.

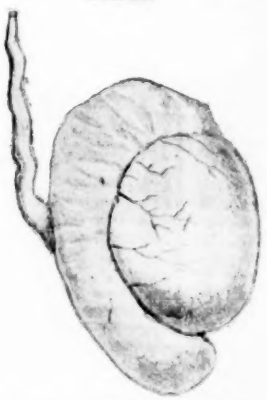
While residing in Paris in the summer of 1890 I began, through the kindness of Professor Dastre, of the Experimental Physiological Laboratory of the Sorbonne, to whom I am much indebted, a series of experiments on the testicle in dogs, and have since conducted some at Cambridge. I made use of puppies and of full-grown dogs. In most instances, after exposing the spermatic cord in the groin I opened the processus vaginalis and seized the vas deferens and ligatured it with a piece of strong sterilised silk; in others I made use of two catgut ligatures and divided the cord between them. The wounds as a rule healed by first intention, and when they did not there was only a superficial wound left to granulate, which did not interfere with the dog running about and appearing as lively as ever. I will give an account of only a few of my experiments and will group them for convenience under the following headings: (1) ligation of the vas deferens in puppies; and (2) ligation of the vas deferens in full-grown dogs.

1. *Ligation of the Vas Deferens in Puppies.*

CASE 1.—A fox-terrier puppy about two months old. On June 23th, 1890, the right vas deferens was tied in the inguinal region with sterilised catgut. On the following day no change was observed in the corresponding testicle. On July 1st, three days later, the dog was killed. The right vas deferens was completely occluded, but there was no difference between the two testicles. After hardening in spirit no change whatever between the two testicles could be detected by the microscope.

CASE 2.—A puppy sheep-dog about four months old, whose testicles were as yet small and undeveloped. On Dec. 29th, 1890, the left testicle was removed, and the right vas deferens was ligatured just outside the inguinal ring with sterilised silk thread. There was no change in the testicle after the operation, and both wounds healed rapidly, the animal soon getting well. In the beginning of April, 1891, the testicle (right) began to show signs of growth, and it grew rapidly until at the end of the month it was of nearly natural size. The animal was killed. This right testicle is illustrated in Fig. 17, because it shows in a remarkably clear manner the

FIG. 17.



Right testis of dog. (Experiment 1.) Body of testis somewhat globular in shape, epididymis much enlarged from distension of its tubules, and vas deferens distended up to seat of ligature.

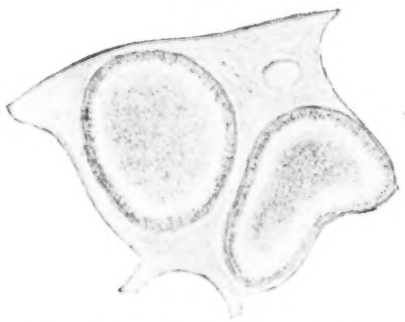
changes that arise after a certain period in the epididymis, and also those in the testicle, the latter being much less marked. The epididymis is greatly swollen, the lobules of the upper part being especially prominent, as are also the convolutions of the duct below, though these are not so well represented in the drawing. This enlargement of the epididymis, and indeed of the vas deferens, up to the seat of ligature is dependent upon over-distension due to the accumulation of the seminal fluid secreted by the testicle. The body of the testicle had assumed a globular shape, thicker and somewhat more tense than a testicle the secretion of which is allowed to pass away freely. Under the microscope this testicle presents the appearance of a perfectly healthy active gland; and in the epididymis the only changes are those of dilatation of all the tubules, their cavities being filled with seminal secretion abounding in well-formed spermatozoa.

2. Ligation of the Vas Deferens in full-grown Dogs.

CASE 3.—A large sheep-dog from three to four years old. On June 24th, 1890, the left vas deferens was tied in two places and divided between them. On the following day (25th) the left testicle and epididymis were slightly swollen and tender. No unusual sexual excitement was noticed in this case, and no further changes were observed. The animal was killed on July 1st, seven days after the operation, and the organs were placed in strong spirit. Under the microscope the seminal tubules appeared normal, showing the natural formation of spermatozoa. In some tubules there were many small, round homogeneous bodies of about the size of red blood-corpuscles; these stained of a delicate pink colour with carmine and are probably of the nature of mucin bodies. The tubules of the epididymis contained spermatozoa, and showed no signs of a structural change in the epithelium or in the intervening connective tissue.

CASE 4.—A fox-terrier eighteen months old. On Oct. 30th, 1890, the left vas deferens was ligatured with sterilised silk thread in the groin. The wound healed quickly, and the animal was soon well and running about. On the following day, Nov. 1st, the testicle as well as the epididymis was enlarged and tender; this passed away, but reappeared on Nov. 10th; and on Dec. 20th the testicle was apparently smaller, firmer, and more tender than natural. No further change took place until Jan. 22nd, 1891, eighty-three days after the operation, when the animal was killed. The epididymis, as also the vas deferens up to the seat of ligature, was found distended, though not to any great extent, but the body of the testicle presented nothing abnormal in shape or size. Microscopically the testicle is quite normal, the seminal tubules being well formed, showing abundance of spermatozoa in their interior, and the process of spermatogenesis could be traced in most of them. In the epididymis the epithelial cells lining the over-dilated tubules have lost their tall columnar character, and are reduced to low cubical cells which do not bear cilia as do the natural columnar cells. Further, the cells thus flattened are found in several layers; the walls of the tubules are unaltered, and the intervening connective tissue remains unchanged and free from any signs of inflammation. (Fig. 13.)

FIG. 13.



Section of epididymis of a dog after ligature of vas deferens. × 35.

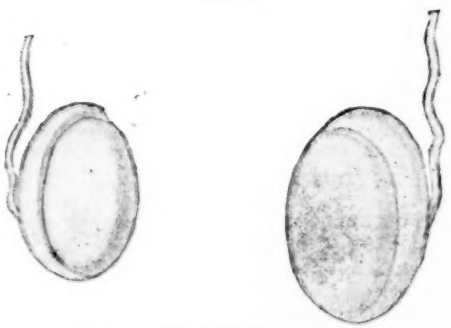
Accordingly, when the vas deferens is ligatured in puppies there is no immediate result either upon the epididymis or testicle; nor is the growth of the latter in any way interfered with—that is to say, the ligature of the duct does neither hasten nor retard the growth of the gland, and the testicle acquires its maturity both of structure and function just as if the duct had been left alone in its natural and pervious state. Again, when the vas deferens is ligatured in full-grown dogs there occurs enlargement of the epididymis, with tenderness. This enlargement in part subsides, leaving it, together with the portion of the duct up to the seat of ligature, permanently enlarged from the accumulation of semen. The structure of the seminal tubules remains unaltered, and they are after a few days or a few months just the same, showing the active formation of spermatozoa, as those of the normal testis, the duct of which is left natural and undisturbed; therefore ligature of the vas deferens induces a slight enlargement of the epididymis and of the vas deferens up to the seat of ligature, but it does not interfere in any way with the structure of the seminal tubules or the production of spermatozoa. This is in accordance with the views of Hunter, Cooper, Curling, Gosselin, and Godard, and in part with those of Brissaud. Curling and others, who were aware, both from experiment and observation, of the independence that exists between the growth of the testicle and that of its duct, considered that this independence was due to the manner in which the testicle and vas deferens took separate origin in the embryo. It is now generally well known that the testicle arises from a modification of the germinal cells of the body cavity, while the vas deferens (Wolffian duct) is either a segmentation from the epiblast near the dorsal groove or takes origin in the intermediate cell mass as a solid rod which soon becomes hollowed into a tube or duct, and subsequently these two become united by the development of intermediate tubules which form the vasa efferentia, and which effect a communication between the numerous seminal tubules on the one side and the canal of the epididymis on the other. Accordingly, the testicle and its vas deferens have each of them, like the kidney and its ureter, a separate origin in early embryonic life, and in this respect they differ from other glands. It may be questioned, however, whether this is really an explanation of the fact that when the vas deferens is ligatured or in great part destroyed by disease the testicle grows to its full size and acquires its function as if there had been no interference. Such an explanation as that adopted by Curling, attractive as it may seem, is not only unnecessary but probably erroneous, and some other reason than independence of origin in development must be sought for. Up to the time of adolescence the testicle and the vas deferens constitute together an unused apparatus which simply grows gradually in each of its parts preparatory to the greater development at puberty; and the whole genital system is an apparatus the potentiality of which mainly depends upon the integrity of the testicles, one or both, and that they control the extent to which the remainder of the sexual apparatus grows, the growth of the vas deferens no less than that of the prostate and other accessory sexual glands. I make this statement because in observations upon castrated animals I have found that the testicle exerts (see Lecture I.) such an influence upon the growth of the other parts of the sexual apparatus, while I have found nothing to indicate that any other part of this apparatus exerts even the slightest control over the growth of its neighbour or over that of a distant part. When, for example, the vas deferens is, either in part or in the entirety of its length, destroyed the testicle and the remainder of the apparatus on that side of the body, including the vesiculæ seminales and prostate, continue to grow without any observable modification until they reach their full size. Further, it is not until that full size is attained and the functional powers of the gland as a secreting organ are well established that any imperfection resulting from the obliteration of the vas deferens becomes manifest except such as I have mentioned. Therefore any injurious influence which that obliteration may give rise to may reasonably be inferred to be the result of interference with the due expulsion of the semen from the gland and of its accumulation in the part of the duct still unobliterated.

It may be observed that in other organs, where the duct is occluded by disease or otherwise, the secretion as it is formed is prevented from making its proper escape, accumulates, and in time, if not small in amount and absorbed, tells injuriously upon the secreting tubules. For example, ligature of the biliary duct induces a variety of cirrhosis of the liver if the obstruction be permanent and complete, as shown by the researches of Wickham Legg and afterwards by Charcot and others; and this change follows in virtue of the damming up of the bile, first in the biliary ducts and ultimately in the bile capillaries, the secretion of bile going on more or less continuously until the liver cells become destroyed by the pressure of their own secretion. In the testicle, however, the same result does not usually follow except to some extent in the epididymis. May not this result either from the great length of its tubules and the slow secretion of spermatozoa or from the absorption of the seminal fluid taking place in proportion to its rate of secretion? This view seems to be on the whole confirmed by the observations of Brissaud in the rabbit and of myself in the dog and in man. Brissaud, it may be remembered, obtained, after ligation of the vas deferens, different results according to the conditions under which the animals were placed after the operation. For example, if, on the one hand, the rabbits operated upon were placed by themselves, nothing more than a passing enlargement of the epididymis and

testicles occurred, similar to that which has been shown above to occur in full-grown dogs; but if, on the other hand, they were placed with does different results occurred—results in which the structure of the testicle becomes like that of a testicle before its full development at puberty or during the non-rutting period of rutting animals. In the latter series the testicle passed through a period of super-activity that was followed by certain atropine changes in the structure of the seminal tubules, and by means of these changes the testicle becomes transformed into the state above referred to. It seems clear, therefore, that Brissaud found some atrophic changes in the testicle consequent on his experiments. I can, however, scarcely agree with his statement that these changes correspond with the condition before puberty or with that in the non-rutting period of rutting animals. But I would note that the structure of the testicle under these conditions, as gathered both from the description and drawing given by Brissaud, does not quite bear minute comparison with that either of the undeveloped organ or of one of a rutting animal during the non-rutting season. In the rabbits that were subjected to the sexual influence of the does the testicle represented by him shows that the seminal tubules were much reduced in size, and the epithelial lining of the interior was in many places represented by a single layer of small cubical cells surrounding a rather large central lumen; the intertubular connective tissue was increased, and in some places it was denser and more fibrous than natural, whereas in the undeveloped organ—twenty or more of which I examined—the seminal tubules were in all instances solid rods of epithelial cells, and I also found this to be the case in the testicles of rutting animals during the non-rutting period, as has already been pointed out in Lecture II. Further, the amount of intertubular connective tissue or stroma is not in increased quantity. The essential histological features, therefore, of the two conditions differ, and the two states are distinct from one another.

CASE 5.—A hound from eight to nine years old. On June 11th, 1890, the right vas deferens was ligatured with sterilised catgut and the left testicle removed. The wounds healed quickly, and but little change occurred in the right testicle for three or four days except for some tenderness, especially of the epididymis. On June 16th there was great sexual excitement, erection of the penis being more or less constant during the day, and the parts were tender. On June 18th swelling of the lower end of the epididymis became distinct, and sexual excitement, though somewhat less than on the previous days, was yet strongly marked. On June 25th the testicle itself was found to be appreciably reduced in size and softer than natural, but not nearly so tender as it was a week previously; the epididymis still remained of large size.

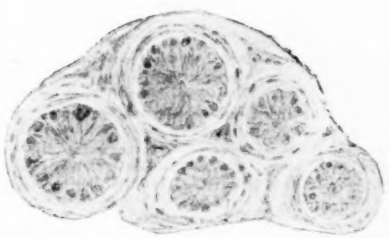
FIG. 19.



Testes of dog (Experiment 5) twenty-one days after ligature of right vas deferens. Left testis of full size. Right testis considerably reduced in size.

The testicle became gradually less in size, and it acquired a more globular shape than natural. On July 2nd the dog was killed, and the organ was placed in strong spirit. The body of the left testicle, which was removed when in a healthy state, is ovoid in shape, measuring 30 mm. in length and 17 mm. in breadth; while that of the right, the duct of which was ligatured, is less and of a more globular shape, measuring 25 mm. in length and 14 mm. in breadth, a difference which indicates a considerable diminution in entire bulk (Fig. 19). The epididymis, however, is enlarged, especially at its lower end, the upper part, or head, and the body having during the last week or so become considerably diminished, owing probably to the disappearance of the secretion that had overfilled its tubules. In this (the right) testicle the seminal tubules are much reduced in size and in number, but the intervening connective tissue is not much, if at all, changed. The tubules, of which none are normal, show different degrees of wasting; those tubules that are least changed have a thickened tunica propria lined by a single layer of small cubical cells, the middle of the tubules being occupied by larger and irregularly shaped cells which do not show any traces of the formation of spermatozoa, whereas those that exhibit the most advanced changes have a much thicker tunica propria, and the epithelium in their interior is reduced in most instances to a single layer, which is of the columnar variety. These columnar cells rest with their bases or outer ends upon the altered and thickened tunica propria, and their inner ends taper towards the centre and occupy the middle of the tubule, as seen in Fig. 20. The tunica propria is divisible, when much thickened,

FIG. 20.



Section of right testis of dog. (Experiment 5.) Seminal tubules with thickened tissue lined by a single layer of tapering fibrillated columnar cells.

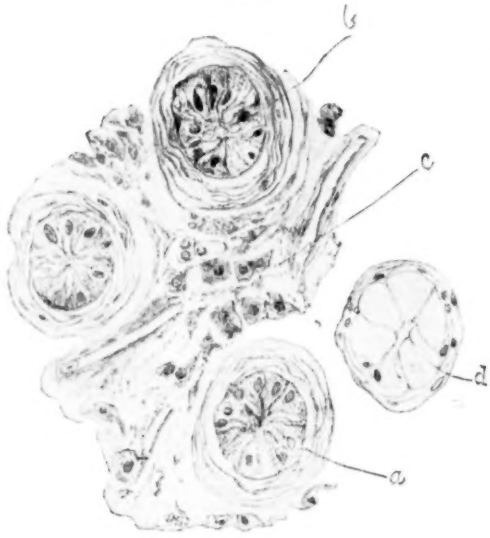
into two layers—an outer thin layer of connective tissue, resembling the original tunic, and an inner, more transparent one, with wavy fibrils traversing it. This inner layer seems as if it had been formed from the connective tissue of cells of the normal tunic which had remained more or less unaltered. In the epididymis the muscular coat of the tubules is infiltrated with connective-tissue cells, and the intertubular stroma is increased and denser than natural, but the epithelium of the tubules is hardly altered.

Similar results occur in man, as shown by the following specimen, the only one that I have obtained in which the vas deferens was occluded. The testis was excised from a young managed twenty-one years, six weeks after the removal of an encysted hydrocele of the cord with which had been taken away a portion, about three-quarters of an inch in length, of the vas deferens. After the hydrocele had been removed the testis, which was previously normal, swelled and became tender, and owing to the continuance of the pain and tenderness the organ was excised at the man's request. The body of the testis was of about the natural size, but firmer; the epididymis was somewhat enlarged, the tubules being distended, and the tunica vaginalis showed signs of previous inflammation. The seminal tubules were reduced in size and in number, and the intertubular tissue was relatively increased. In none of the tubules could the natural arrangement of the seminal cells be seen; and in none of them were there any evidences of spermatozoa or of spermatogenesis. In the tubules that were the least changed the seminal cells were represented by a single layer of small cubical cells at the periphery of the tubules, and a number of irregularly shaped cells occupying the lumina (Fig. 21). In the tubules that were much reduced the seminal cells were represented by a single layer of columnar cells enclosing a small central lumen. In these tubules the tunica propria was not much altered, but between it and the epithelial cells there was a thick layer of almost transparent fibrillated connective tissue which arose from the inner cells of the tunica and took the place of the receding and dwindling epithelial cells. In a few tubules the epithelial cells had completely disappeared, leaving a narrow fissure-like lumen, the two parts of the tunica propria only representing the tubule. The stroma

consisted largely of cellular connective tissue, with here and there a considerable formation of a fibrous matrix. The tubules in the epididymis were not much altered, and the intertubular connective tissue was natural. Thus the changes that occurred in this specimen were practically identical with those in the preceding one from a dog.

Are these changes dependent upon simple ligation or severance, or are they the result of some damage to and subsequent interference with the blood flow through the spermatic vessels? Seeing that ligation of the vas deferens may be practised on full-grown dogs over and over again without producing any destructive changes in or atrophy of the seminal tubules, and seeing that the testis is usually natural in cases where there is a congenital deficiency of the duct in man, it is but reasonable to suppose that there exists some

FIG. 21.



Section of right testicle of a man, aged twenty-one years, six weeks after removal of a portion of the vas deferens with an encysted hydrocele of the cord. × 450. *a*, Tubules lined by a single layer of columnar tapering cells. *b*, Thickened tunica propria.

additional cause when progressive atrophy of the seminal tubules occurs. It is, I believe, true that in the human subject atrophy of the seminal tubules not infrequently follows the removal of cysts or growths of the spermatic cord in which the vas deferens is accidentally ligatured or a part of it excised; but in these cases the tumours or cysts arise from the middle of the cord, and as they grow they spread out the structures (the vessels and nerves) of the cord upon them; accordingly, when such tumours or cysts are removed the spermatic vessels and nerves have to be carefully dissected off, and during this process I apprehend that damage is done to them. When, therefore, a portion of the vas deferens is accidentally removed under the above circumstances the testicle is influenced, not only by the results of the damming up of its secretion, but also by the damage done to its bloodvessels in the spermatic cord. It would hence seem that mere division, ligation, or occlusion of the vas deferens does not lead to atrophy of the seminal tubules; but if in case of division there is, in addition, some damage to the other structures of the cord destructive changes, followed by atrophy and ultimate disappearance of the seminal cells, are liable to occur.

With regard to the suggestion made by Mr. Reginald Harrison of division of the vas deferens in cases of enlarged prostate I have not sufficient experience to arrive at a conclusion; but, seeing that obliteration of the vas deferens has so little effect upon the structure and secretion of the testis, it must be doubtful whether the operation will suffice to influence the enlargement of the prostate.

INTERSTITIAL KERATITIS AND SYNOVITIS,

WITH REPORT OF A CASE IN WHICH BOTH WERE UNILATERAL.

BY G. CRAWFORD THOMSON, M.D. DURH.

(*Continued from p. 861.*)

Interstitial keratitis and inherited syphilis.—I am aware that to some authorities the coexistence of interstitial keratitis and synovitis, to others even the existence of interstitial keratitis alone, will be sufficient for the diagnosis of syphilis, even if there is no other evidence in the condition of the patient, in his previous history or that of his relatives; but, as far as I have been able to ascertain, the present position of the question, judged from the results of the most reliable observers, does not justify these rigorous conclusions. This statement is in antagonism to another rule laid down by Hutchinson[1]: "Interstitial keratitis in its typical form is always a consequence of syphilis and in itself sufficient for the diagnosis." But, as shown by a table of statistics recently published by Dr. G. Ogilvie,[2] the results of most other ophthalmic surgeons do not bear out the above rule. The highest percentage was found by Parinaud (96·7 per cent. in the comparatively small number of thirty-two cases), but he also admits that the corneal lesion has nothing specific and is observed outside syphilis.[3] Nettleship, amongst 240 cases, found evidence of hereditary syphilis other than corneal disease in 68 per cent., and in the remaining 32 per cent., almost without exception, strong suspicion.[4] The 68 per cent. of cases with other syphilitic symptoms are in accord with other observers, while the 32 per cent. of suspicious cases are considerably in excess of the results of others. But here much scope is left to the individual interpretation of facts. The polymorphous character of inherited syphilitic lesions is well known, so is the fact that not one of them is really pathognomonic; therefore, two, or even more, symptoms met with in syphilis might coexist without being produced in a particular case by that disease. Snuffles and a rash on the buttocks exactly imitating the specific form, appearing about six weeks after birth, are not sufficient for the diagnosis.[5] In the same way any other symptom met with outside inherited syphilis, even if complicated by interstitial keratitis, will also not be sufficient proof, and it is here where the individual judgment of the observer plays a rather arbitrary part. Therefore, statistics drawn up by different observers cannot safely be compared unless the principles on which they are based are practically the same. This condition is fulfilled in the statistics I am now going to quote. The percentage generally found, if drawn from a sufficient number of cases, is between 60 and 70: Ancker, 61 per cent.; Horner, 70·5 per cent.; Fournier, between 70 and 75 per cent.; Jakowlena, 57·1 per cent.; Saemisch, 63 per cent.; Wecker, 66 per cent.; and Pfister, 64 per cent. Panas,[6] combining the numerous statistics on the subject, finds the average to be from 40 to 41 per cent., but this is decidedly too low and probably due to non-comparable statistics being compared. Fournier,[7] also granting the part which hereditary syphilis plays in the production of interstitial keratitis (in 212 cases of hereditary syphilis he saw 88 of interstitial keratitis), says: "It is incontestable that interstitial keratitis is met apart from any specific influence" (p. 216); and: "Interstitial keratitis is neither cachectic, nor scrofulous, nor a syphilitic lesion, but 'une lésion vulgaire banale,' a simple lesion of nutrition which can be produced by different morbid influences" (p. 218).

Another argument against the exclusively specific nature of interstitial keratitis, given by Ogilvie, is that it has been observed in dogs, and experimentally produced in rabbits. Since the publication of his paper several cases of interstitial keratitis have been observed in bears by Hennicke,[8] and the diagnosis has been confirmed by microscopical examination,

[1] Syphilis, p. 75.
[2] A Rare Case of Hereditary Syphilis, with Remarks on Interstitial Keratitis; THE LANCET, June 10th, 1893.
[3] Archives Générales de Médecine, November, 1883.
[4] Berkeley Hill: Syphilis, p. 263. London, 1881.
[5] Hutchinson: Syphilis, pp. 81, 411.
[6] Traité des Maladies des Yeux, 1894, vol. i., p. 245.
[7] La Syphilis Héréditaire Tardive. Paris, 1886.
[8] Klinische Monatsblätter für Augenheilkunde, 1894, pp. 133–136.

which, besides diffused interstitial inflammation of the cornea, revealed inflammatory changes in the ciliary body and in the equatorial regions of the choroid. Ogilvie's argument is exactly the same as the one adduced by Hutchinson[9] for the non-syphilitic character of rickets and scrofula: "That rickets and scrofula are both of them frequently met with in the lower animals, and that they may, indeed, be produced artificially under conditions which make the influence of syphilis an impossible hypothesis." Again we find Mr. Hutchinson referring to the fact that miscarriages are abundantly frequent in our domestic animals in order to prove that the influence of syphilis in the production of abortion is probably overrated;[10] and protesting against the condition known as the macerated fœtus being accepted as an indication of syphilis, he also takes his argument from the fact that nothing is commoner than the macerated lamb, calf, or foal (p. 416). If this argument holds good for rickets, it holds good as well for interstitial keratitis, and then the experiments of Wagenmann, to be referred to later, and the observations of Haltenhoff, Randolph, and Hennicke disprove the exclusively specific character of interstitial keratitis.

According to Fournier[11] four theories exist concerning the causation of interstitial keratitis: (1) that it is a cachectic malady—"une manifestation de la misère organique" (Panas); (2) that it is produced by scrofulous or strumous disease (W. Mackenzie); (3) that it is exclusively, or nearly exclusively, due to syphilis (Hutchinson); and (4) that it is a lesion of general nutrition (Fournier). He dismisses (2) with little comment, as no connexion with strumous disease could ever be proved; he considers (3) to be contrary to the clinical facts, as interstitial keratitis is met with apart from any specific influence; and refutes (1) because interstitial keratitis is met with in subjects otherwise apparently healthy, and in private as well as in hospital practice. I fail to see that Fournier's explanation differs materially from that of Panas. "A lesion of general nutrition," "cachexia," and "organic misery" are only different expressions for the same condition or for different degrees of the same condition. Therefore, the fact that interstitial keratitis is met with in apparently healthy subjects is explicable by either theory only in one and the same way—viz., that the defective general condition in these cases is apparent as localised or limited to one special organ. This same view has been quite recently taken by Panas,[12] who admits that between Fournier's dyscrasia and his cachexia practically no difference exists, and that he therefore willingly accepts Fournier's denomination instead of his. From the above the conclusion has to be drawn that in the production of interstitial keratitis hereditary syphilis is probably operative in between 60 and 70 per cent.

With regard to the affection of the joint we have no similar statistics to be guided by, but that the appearance of interstitial keratitis, with or after effusion into the knee-joint, need not be in itself conclusive proof of hereditary syphilis has already been suggested by Foerster. Arlt[13] has seen this painless and benign knee affliction in ten cases of interstitial keratitis, all of them non-syphilitic. Lavergne[14] has put together fifty cases of interstitial keratitis. Syphilis was absolutely certain in nineteen cases, very probable in thirteen, probable or doubtful in twelve, and could be excluded in six. He mentions only one case of effusion into the knee-joint, and this case is to be found amongst the six in which he excludes syphilis. I, therefore, from my own case as well as from the experience of Arlt and Lavergne, draw the following conclusions. Neither interstitial keratitis nor the synovitis, nor their coexistence, is in itself absolute proof of hereditary syphilis; that the joint disease also is due to a general defect in nutrition, in the production of which inherited syphilis plays a prominent part, the extent of which we are not able to give in figures. In what this disturbance of general nutrition consists, what general condition constitutes the connecting link between interstitial keratitis and synovitis, is merely a matter of conjecture. But some light will perhaps be thrown on this point afterwards by reference to the pathology of interstitial keratitis.

Interstitial Keratitis and Rheumatism.—Obscure as is the connexion between the two affections, interstitial keratitis and synovitis, it is certainly not produced by rheumatism, although this interpretation has been given to their combined appearance by writers here and abroad. Undoubtedly the existence of swollen joints was regarded as evidence of rheumatic disease without taking the other possible causes into due consideration. If in the causation of interstitial keratitis acute rheumatism played any part this fact would be referred to in the text-books on this disease of everyday occurrence; but in not one of the leading English, German, or French works on rheumatism can we find mention of it. Mitchell, Bruce, and Senator do not refer to eye complications at all; according to Homolle the visual organ is not affected in acute rheumatism; Charcot says that affections of the eyes in acute rheumatism are exceedingly rare; Besnier that the eye enjoys a nearly complete immunity from disease; and Archibald Garrod that the eye is little liable to be attacked in the course of rheumatic fever. All give as the only ophthalmic complication a troublesome conjunctivitis in no way characteristic, and probably identical with what is met with in other fevers. The eye itself is not attacked, with the only exception of the superficial vesicular form of keratitis consisting in the elevation of the epithelium in small blisters and superficial ulceration after their bursting (Terrier).[15] This keratitis is met with occasionally in any febrile disease with predilection to affections of the respiratory tract, from a simple cold to a pneumonia, and, being frequently accompanied by herpes of the lips, with which it is pathologically identical, has been properly called "herpes of the cornea" (Horner). In subacute and chronic rheumatism, however, eye affections are by no means rare (Bennett, Watson, Garrod, Fuller, Cornil, Charcot, Besnier, Hutchinson, Homolle, and others). The lesions observed are iritis, cyclitis, scleritis, and episcleritis; but nowhere is interstitial keratitis given as a rheumatic complication. From this fact alone the cases of interstitial keratitis published as of rheumatic origin have to be received with considerable suspicion. By some Foerster has been represented as having first demonstrated the rheumatic origin of interstitial keratitis, although he wishes the difference between the joint affection described by him and the rheumatic to be clearly understood. Spencer Watson, in a paper already referred to, gives four cases of interstitial keratitis associated with synovitis of the larger joints (knee three times, elbow once), which he ascribes to acute rheumatism. Apart from there being strong evidence of hereditary syphilis in at least three of them, the acute rheumatic nature of the synovitis is not proved in one, there being, for instance, no notes as to temperature. Instead of questioning, as Mr. Watson does, "whether the keratitis of inherited syphilis is not a form of rheumatic ophthalmia," it would have been more to the point to inquire whether the form of synovitis met with, the keratitis of inherited syphilis, was not of other than rheumatic origin. A remarkable and perhaps unique case under the care of Dr. Armstrong of Newcastle-on-Tyne has been reported by Maynard.[16] The patient was suffering from severe interstitial keratitis, and had a clear history of congenital syphilis and effusion into both knee-joints, ankles, wrists, and finally elbows. Although the sweating and rise of temperature were in favour of rheumatic joint disease, Dr. Armstrong is inclined to attribute the joint affection to syphilis, on the ground of the rapidity and long duration of the effusion, the absence of redness of the skin, the relaxation of the ligaments with increase of mobility, and the previous history. But whatever view may be taken of the nature of the joint affection, the interstitial keratitis is sufficiently explained by the evidence of hereditary disease, and cannot be put down to rheumatism. Couzon[17] mentions that he has seen two or three cases of interstitial keratitis without any trace of syphilis, but with rheumatic articular manifestations which disappeared with the keratitis. Of these cases he reports only one. This case, also referred to by Perinaud,[18] is the only one I could find in which the connexion between rheumatism and interstitial keratitis has been established with some probability. But as nothing else is known about the connexion between rheumatism and interstitial keratitis, the case has to be regarded as an exceptional coincidence rather than as one proving a pathological connexion otherwise not borne out by clinical experience.

Syphilis, p. 408.

[10] Ibid., pp. 78, 79, and 415.

[11] Loc. cit., p. 218.

[12] Traité des Maladies des Yeux, vol. i., p. 245. Paris, 1894.

[13] Krankheiten des Auges, p. 113. Vienna, 1881.

[14] De la Kératite Interstitielle, p. 57. Thèse, Paris, 1887.

[15] Archives d'Ophthalmologie, vol. iv., p. 65. Paris, 1884.

[16] Brit. Med. Jour., vol. i. 1887, p. 569.

[17] De la Kératite Interstitielle dans la Syphilis Héréditaire et dans la Syphilis acquise. Thèse. 1883. pp. 43-45.

[18] Archives Générales de Médecine, 1883, p. 533.

The coexistence of interstitial keratitis with synovitis has led to the erroneous diagnosis of rheumatism, a mistake which might be avoided by a more careful investigation of the nature of the joint affection and by a less vague use of the word "rheumatic." The connexion between rheumatism and interstitial keratitis as cause and effect has neither been established by the experience of general medicine nor by that of ophthalmology in special.

Pathological anatomy and pathology of interstitial keratitis.—It is self-evident that a disease with a decided or almost invariable tendency to recovery only rarely presents itself for anatomical examination. No example of a typical uncomplicated case of interstitial keratitis has yet come into the hands of the pathologist. The cases which have been examined were the rare exceptions of malignant destructive character, and were seen at a stage when the actual inflammatory process had led to considerable consecutive changes such as cicatrisation, perforation, glaucoma, &c. Besides, amongst the cases which, from a pathologico-anatomical point of view, have been described as interstitial or parenchymatous keratitis, some have absolutely nothing to do with the disease in question, being instances of diffused corneal affection brought on through general disease of either the whole globe or the anterior part of it, sometimes of tuberculous, sometimes probably of embolic, origin. This remark applies first of all to Virchow's[19] case, which is constantly quoted as the first case of interstitial keratitis examined microscopically. After an intense diffuse phlegmonous inflammation of the extremities, which ended fatally, the cornea became affected (the patient was under the care of von Graefe). It is more than likely that the purulent inflammation of the eye, of which the corneal affection was probably only part, was caused by some embolism from the destructive changes going on in the lower extremities, and that the case ranks with those of metastatic or embolic choroiditis, subsequent to puerperal or other septic processes. The second case usually referred to is that of Kruckow.[20] Both eyes were removed a few hours post mortem from the body of a woman aged forty-eight years, the subject of old acquired syphilis, who died from large gummatous tumours in the brain and petrous portion of the temporal bone. The information given on the localisation of the disease and the microscopical changes of the corneal tissue is very scanty; anyhow, double keratitis in acquired syphilis at the age of forty-eight years, if interstitial at all, must be considered a most exceptional case, and not one from which conclusions can be drawn on the ordinary form. A much fuller description of the anatomical changes is given by Baumgarten.[21] But here, too, the clinical history has nothing in common with what is properly called interstitial keratitis, and the case is therefore rightly described by him as one of "sclerosirende keratitis," meaning an inflammation of the cornea in which it assumes a sclera-like appearance. The patient was sixty-three years of age, a time of life at which interstitial keratitis is practically unknown. O. Meyer[22] quotes the last two cases mentioned as the only two examined histologically which with full certainty can be considered as typical specimens of interstitial keratitis (p. 5). As said above, the last case can under no circumstances be so classified, presenting a rare affection clinically absolutely different to interstitial keratitis; while Kruckow's case is at least doubtful. His own case, regarded by him as the third of undoubted interstitial keratitis examined anatomically, is subject to doubts as grave as in the other cases. The patient, who was under the care of Dr. Swanzy in Dublin, had phlyctenular ophthalmia when twenty years of age, circumscribed scleritis a year later, and five months after that on the inner surface of the cornea a yellowish white deposit began to form without any inflammatory redness of the globe. It spread from its original seat gradually over the whole posterior surface of the cornea, and while the process was going on absorption of the exudation began at the starting point, so that it had disappeared there when it had reached the opposite side, leaving a diffused opacity behind. In my opinion, taking the clinical and anatomical observations together, it is most probable that some tuberculous process involving the anterior part of the globe had led to secondary infiltration of the cornea. Von Hippel, jun.,[23] has described the case of a boy, probably subject to hereditary syphilis, who had been under treatment for parenchymatous keratitis with iritis for several weeks. He died from laryngeal croup. The changes found in the cornea were vascularisation and a rather typical cellular infiltration, as well as inflammatory changes in all parts of the eye, presenting themselves partly under the form of typical giant cell tubercles without caseation. To this case exactly the same remarks are applicable as to the former. A case of undoubted interstitial keratitis under the care of Hirschberg, and described by him as malignant diffuse keratitis, had led to glaucoma, enlargement of the globe, cornea globosa, complete cicatrisation of the latter, in fact, to total disorganisation of the eye, when it was examined by Birnbacher.[24] Another case, undoubtedly due to hereditary syphilis, and microscopically examined by Mr. Nettleship,[25] although interesting enough in itself, especially as far as the fundus of the eye is concerned, is not conclusive with regard to the anatomical condition of the cornea in interstitial keratitis, because it was complicated with trauma of the cornea. The patient was under the care of Mr. Brudenell Carter, suffering from interstitial keratitis with iritis, when the left eye was ruptured by a poke from an umbrella stick.

Up to the present date pathological anatomy supplies us with scarcely any information as to the histological process underlying the clinical aspect of interstitial keratitis. Out of seven cases quoted above, which, according to my knowledge, constitute the complete list of cases diagnosed as interstitial keratitis, and examined microscopically, four—those recorded by Virchow, Baumgarten, Meyer, von Hippel—cannot clinically be considered as specimens. Kruckow's case is, at least, doubtful and rather incomplete. The two undoubted cases are not conclusive for the reasons given above; one (Birnbacher) because it was examined at too late a stage, the second (Nettleship) because it was complicated by injury; therefore the greater value seems to me to be attached to the researches of Wagenmann,[26] who succeeded in producing interstitial keratitis experimentally by section of the ciliary arteries, thereby affording an opportunity of examining anatomically all stages of its course, and particularly the non-malignant form, ending in recovery and mostly met with in clinical experience. As both affections, the one produced experimentally and the one known clinically as interstitial keratitis, are perfectly analogous in appearance as well as in the course they run, it is probable that the interstitial keratitis of man also is only a secondary consequence of the disease of the choroid.

Conclusions.—Here the results of experimental research are in accordance with the observations of clinical experience. The so-called interstitial keratitis is not a primary inflammation of the cornea, but one probably originating in the anterior part of the uvea, which provides the nutritive supply for the corneal tissue. It is not a characteristic symptom of hereditary syphilis, but is due to an insufficient supply of nutritive matter to the cornea, whether this is produced by cutting off the blood-supply experimentally or by diminution of the lumen of the bloodvessels through the thickening of their walls. That this latter condition (Heubner's endarteritis) is to be found in syphilitic disease of the retina and choroid, as well as in brain syphilis, has been shown by many observers. Compare, for instance, the interesting case of Dr. Barlow and Mr. Nettleship in vol. xi. of the Ophthalmic Hospital Reports. Clinically it is known that syphilis plays an important part in the production of anæmia, and perhaps in this way the surprising fact might be interpreted that boys are much less frequently the subjects of interstitial keratitis than girls (Hutchinson, amongst 102 cases, 64 females and 38 males), the great proneness of the female sex to an anæmic condition being undoubted. An interesting observation of Klebs might be mentioned in connexion with the foregoing consideration. In animals which, after inoculation with the syphilitic virus, do not develop any symptoms that could be clinically considered as parallel to the characteristic symptoms in man, frequently a state of profound anæmia is produced with a tendency to hydropic effusion.[27] It is most probable that the affection of the knee-joint is to be explained

[19] Cellular-Pathologie, fourth edition, pp. 376-82. Berlin, 1871.
[20] Monatsblätter für Augenheilkunde, vol. xiii., pp. 494-497. 1875.
[21] Graefe's Archiv, vol. xxii., Part 2, pp. 185-203. 1876.
[22] Ein Fall von Keratitis Parenchymatosa mit Sectionsbefund. Thesis. Göttingen, 1887.
[23] Report on the Twenty-third Meeting of the Ophthalmological Society, Heidelberg, 1893, p. 221.
[24] Centralblatt für Augenheilkunde, vol. x., 1886, p. 101.
[25] The Royal London Ophthalmic Hospital Reports, vol. xi., pp. 9-12, 1887.
[26] Experimental Researches on the Influence of the Circulation in the Retinal and Choroidal Vessels on the Nutrition of the Eye, particularly of the Retina, and on the consequences of Section of the Optic Nerve: Graefe's Archiv, vol. xxxvi., Part 4, pp. 1-220.
[27] Archiv für Experimentelle Pathologie und Pharmakologie, p. 180. Leipzig, 1878.

in a similar way. The fact that it is the knee-joint which is most frequently affected, although not exclusively so, might be explained by its synovial membrane being the largest and by the exposed condition of the joint. I am not aware of any clinical facts which would show a similar synovitis following the arrest of blood-supply to joints by obliteration or compression of bloodvessels. To attack this question experimentally on the same lines as Wagenmann has done with regard to the ciliary vessels would be a matter of no common interest, and one which I hope to be able to approach at no distant period.

Sinclair-road, W.

RESULTS OF

MAJOR AMPUTATIONS TREATED ANTISEPTICALLY IN THE ROYAL INFIRMARY, NEWCASTLE-UPON-TYNE, DURING THE YEAR 1894, AND FOR A PERIOD OF SIXTEEN YEARS AND NINE MONTHS.

BY FREDERICK PAGE, M.D. EDIN., M.R.C.S. ENG.,
SURGEON TO THE ROYAL INFIRMARY, NEWCASTLE-UPON-TYNE, ETC.

DURING the year 1894 69 major amputations were performed in the Royal Infirmary upon 68 patients. In 1 case a patient lost two limbs. Sixty patients recovered and 8 died—a mortality of 11·7 per cent. Twenty-seven of the amputations were for injury, and 6 patients died—a mortality of 22·2 per cent. For disease 41 amputations were performed and 2 patients died—4·8 per cent. The following table gives the results in a tabular form :—

TABLE I.—*Major Amputations treated antiseptically in the Royal Infirmary, Newcastle-upon-Tyne, during the year 1894.*

	Injury.			Disease.			Total.
	No.	Recoveries.	Deaths.	No.	Recoveries.	Deaths.	
Double amputations ...	1	—	1	—	—	—	1
Hip-joint	—	—	—	2	1	1	2
Thigh...	11	6	5	18	18	—	29
Knee-joint	—	—	—	—	—	—	—
Leg	9	9	—	8	7	1	17
Ankle-joint	3	3	—	9	9	—	12
Shoulder-joint	1	1	—	2	2	—	3
Arm	1	1	—	2	2	—	3
Forearm	1	1	—	—	—	—	1
Wrist	—	—	—	—	—	—	—
Totals...	27	21	6	41	39	2	68

Precise Explanation of Deaths.

INJURY.

1. Man, aged forty-two years, died one hour after amputation of both thighs for crushed legs—shock.

2. Man, aged thirty-seven years, died two days after amputation of thigh for contused and lacerated leg and thigh, with wound into knee-joint—shock.

3. Man, aged twenty-four years, died a few hours after amputation of thigh for compound fracture of leg &c.—shock.

4. Man, aged thirty-seven years, died one hour after amputation of thigh for railway smash—shock.

5. Boy, aged nine years, died a few hours after amputation of thigh for compound fracture of leg—shock.

6. Man, aged fifty-six years, died seven days after amputation of thigh for compound fracture of leg of two weeks' duration—septicæmia. This patient was admitted and operated upon in a septic condition

DISEASE.

1. Man, aged twenty-two years, died a few hours after amputation at hip-joint for advanced hip-joint disease—shock.

2. Man, aged thirty-seven years, died a few hours after amputation of the leg for ulcers, from shock.

TABLE II.—*Major Amputations treated antiseptically in the Royal Infirmary, Newcastle-upon-Tyne, from Jan. 1st, 1883, to Dec. 31st, 1894, a period of twelve years.*

	Injury.			Disease.			Total.
	No.	Recoveries.	Deaths.	No.	Recoveries.	Deaths.	
Double amputations ...	13	7	6	—	—	—	13
Hip-joint	6	3	3	23	14	9	29
Thigh...	52	39	13	154	144	10	206
Knee-joint	7	7	—	2	2	—	9
Leg	76	69	7	70	67	3	146
Ankle...	26	25	1	122	120	2	148
Shoulder-joint	17	16	1	15	14	1	32
Arm	37	34	3	18	17	1	55
Forearm	36	35	1	31	31	—	67
Wrist	7	7	—	—	—	—	7
Totals...	277	242	35	435	409	26	712

As will be seen from the above tables, during the twelve years from 1883 to 1894 712 major amputations were performed in the Royal Infirmary, and 61 patients died. This is a mortality of 8·5. The period is a long one, and every amputation performed in the infirmary during it is included. To arrive at a correct estimation of these results the nature of the amputations and the actual cause of death must be taken into account. Six patients died after double amputations and 7 recovered. Twelve patients died after amputation at the hip-joint and 17 recovered. Six of the hip amputations were primary and 3 of them proved fatal. Twenty-three were for disease and 9 ended fatally. Twenty-three patients died after amputation of the thigh and 183 recovered. Ten patients died after amputation of the leg and 136 recovered. Two patients died after amputation at the shoulder-joint and 30 recovered. Four patients died after amputation of the upper arm and 51 recovered. One patient died after amputation of the forearm and 66 recovered. Three patients died after Syme's amputation and 145 recovered.

Now I will examine the cause of death in these 61 cases, for, after all, that is the most important consideration. The causes of death were as follows :—

1. Pyæmia	9	7. Phthisis	3
2. Exhaustion	4	8. Syncope	2
3. Tetanus	4	9. Tuberculous meningitis	1
4. Recurrent gangrene ...	6	10. Delirium tremens ...	1
5. Shock and loss of blood	30		—
6. Head injury	1	Total	61

It will be seen that 9 of the deaths are returned as due to pyæmia. This is 15 per cent. of the deaths, but deaths occurring some weeks after amputation, and returned as due to exhaustion, must be looked upon with considerable suspicion, and, therefore, I propose to include the 4 deaths from exhaustion amongst the deaths from septic disease. This gives 13 deaths from sepsis—21·3 per cent. of all the deaths. But there were 712 cases operated upon, 13 of which terminated fatally from some form or other of septicæmia, giving only 1·8 per cent. Tetanus, no doubt, is a form of blood poisoning, and the patients who died from recurrent gangrene would probably be septic, but I do not think I am called upon to include these. If they are to be included, then the mortality will be raised to 23, making 37·7 per cent. of all the deaths due to some form or other of blood poisoning, the mortality of the 712 amputations being, even then, only 3·2 per cent. from blood poisoning of any kind. That only 3 per cent. of the amputations in a large hospital should end fatally through any form of blood poisoning during a period of twelve years shows a marked improvement; and, while this is so, it is significant to find how high the relative

proportion of deaths from blood poisoning remains, more than a third of the deaths being still due to some form or degree of blood poisoning.

The next important factor is shock and loss of blood, and from this cause 30 patients died—all within a few hours of operation—i.e., 49·1 per cent. of the whole number of deaths, and 4·2 per cent. of the 712 amputations. If these 30 unavoidable deaths be eliminated from the statistics, as I think they should be, then we have 682 amputations with 31 deaths, a mortality of 4·5 per cent. for the twelve years.

It is remarkable that no death is returned as having been due to secondary hæmorrhage; that formerly by no means uncommon occurrence seems to have been entirely eliminated by the antiseptic system.

With regard to the deaths from pyæmia and tetanus I am entitled to point out that 3 at least of the 9 cases of septicæmia were admitted in a septic condition, and 3 of the 4 cases of tetanus were also admitted suffering from lockjaw. No case of pyæmia after amputation has arisen since 1891 in the hospital. In that year a man, a confirmed drunkard, died seven days after amputation of his leg from pyæmia. There were no deaths from pyæmia in 1890 or in 1889. The patients who died from recurrent gangrene were all very unfavourable cases for operation. They suffered from spontaneous moist gangrene and died from that cause after amputation. That 3 out of the 9 cases of pyæmia and 3 out of the 4 cases of tetanus treated in the infirmary should have originated in private practice tends strongly to confirm the growing public opinion that patients recover much more satisfactorily after surgical operations performed in properly equipped and managed hospitals than in private houses. This conviction induces the public to prefer surgical treatment in either a public or in a private hospital, when they can get it, to treatment in their own homes, and, I am sure, the preference is a wise one. However true the conclusion Sir Jas. Y. Simpson arrived at may have been when he wrote his paper on the relative mortality after amputation in hospitals and in private practice, the position is certainly very different now. It is reversed, for there are, I am satisfied, more deaths in proportion to the number of operations from what is called "hospitalism" now in private practice than in hospitals—certainly, than in the larger public hospitals.

TABLE III.—*The Number of Amputations performed from 1883 to 1894, with the Mortality of each Year.*

Year.	Injury.			Disease.			Totals.	
	No.	Recoveries.	Deaths.	No.	Recoveries.	Deaths.	No.	Deaths.
1883	23	23	—	25	22	3	48	3
1884	21	19	2	36	35	1	57	3
1885	14	14	—	37	35	2	51	2
1886	25	25	—	41	37	4	66	4
1887	17	15	2	43	43	—	60	2
1888	13	7	6	29	29	—	42	6
1889	23	20	3	29	27	2	52	5
1890	35	32	3	35	33	2	70	5
1891	35	28	7	46	45	1	81	8
1892	16	13	3	30	28	2	46	5
1893	28	25	3	43	36	7	71	10
1894	27	21	6	41	39	2	68	8
Totals	277	242	35	435	409	26	712	61

The age of the oldest patient who died after amputation was seventy-seven, and of the youngest four years.

3 died aged	70 or upwards.	5 died aged	30 or upwards.
7 ,,	60 ,,	8 ,,	20 ,,
11 ,,	50 ,,	14 ,,	10 ,,
6 ,,	40 ,,	6 died under	10 years.

I regret very much that I am not in a position to give the ages of all the patients operated upon, without which the value of the above table is much diminished.

The following table gives the results of all the major amputations performed in the Royal Infirmary, Newcastle-upon-Tyne, from April 1st, 1878, to Dec. 31st, 1894, a period of sixteen years and nine months:—

TABLE IV.—*Major Amputations treated antiseptically in the Royal Infirmary, Newcastle-upon-Tyne, from April 1st, 1878, to Dec. 31st, 1894, a period of sixteen years and nine months.*

—	Injury.			Disease.			Total.
	No.	Recoveries.	Deaths.	No.	Recoveries.	Deaths.	
Double amputations ...	13	7	6	—	—	—	13
Hip-joint	6	3	3	25	14	11	31
Thigh	68	50	18	191	178	13	259
Knee-joint	10	9	1	6	6	—	16
Leg	96	85	11	94	91	3	190
Ankle-joint	30	29	1	138	136	2	168
Shoulder-joint	20	19	1	17	16	1	37
Arm	48	43	5	24	23	1	72
Forearm	44	43	1	35	35	—	79
Wrist	7	7	—	—	—	—	7
Totals...	342	295	47	530	499	31	872

Thus there were 872 amputations, with 78 deaths—a mortality of 8·9 per cent.; 342 of the amputations were for injury, and 47 patients died—13·7 per cent.; 530 of the amputations were for disease, and 31 patients died—5·8 per cent.

From a paper published by Dr. Sam. Fenwick in the year 1848 on the surgical operations performed in the Newcastle-upon-Tyne Infirmary during a period of seventeen years and six months I have taken the following table showing the results of major amputations:—

TABLE V.—*Major Amputations treated in the Infirmary, Newcastle-upon-Tyne, during a period of seventeen years and six months.*

—	Injury.			Disease.			Total.
	No.	Recoveries.	Deaths.	No.	Recoveries.	Deaths.	
Thigh and knee	8	3	5	50	41	9	58
Leg and ankle	38	24	14	74	59	15	112
Shoulder-joint	5	3	2	—	—	—	5
Arm and elbow	24	20	4	11	10	1	35
Forearm and wrist ...	6	5	1	9	6	3	15
Totals...	81	55	26	144	116	28	225

Two hundred and twenty-five patients were operated upon during that period, and 54 died—just 24 per cent. Eighty-one of the amputations were for injury, 3 being double amputations, and 26 patients died—32 per cent. One hundred and forty-four were for disease, and 28 patients died—12·5 per cent. It is interesting to compare these results with those extending over a very similar period some forty years later. The tables indicate to what an extent the work of the institution has increased and how strikingly the mortality has decreased. The precise causes of death are not given by Dr. Fenwick, but there is evidence that a large proportion of the deaths, as would be expected, arose from pyæmia.

Newcastle-upon-Tyne.

GALASHIELS COTTAGE HOSPITAL.—The first annual meeting of the managers of this hospital was held on March 29th in the Burgh Buildings, Galashiels, Mr. Brown (ex-provost) presiding. The report stated that from the opening of the hospital in November, 1893, to the end of December, 1894, there had been fifty-one patients admitted, of whom two died. The income during the same period was £654 and fell short of the expenditure by about £20. The cost of building and furnishing the hospital was £4482. The grounds extend to an acre and a half, picturesquely situated by the river Tweed.

CASE OF ADDISON'S DISEASE; NECROPSY.

BY C. CRAWFORD AITKEN, M.B. EDIN.

ON Nov. 28th, 1894, I was called to see a farm labourer aged fifty-nine years. He complained of weakness, nausea and vomiting, and had been ill for about nine months. His previous health had been very good, and with the exception of a dislocation of the shoulder-joint, sustained through a severe fall five years before, he had never had any serious accident. He gave a satisfactory family history, but two brothers appear to have died from phthisis. His habits as to food and drink were good; his home was comfortable; and his work, though exposing him occasionally to the inclemencies of the weather, was light and wholesome. His original occupation was that of a butcher, but in 1889 he had been obliged to resign it and turn for a livelihood to farm labour. The illness of which he complained commenced insidiously. The initial symptoms were languor, depression of spirits, and fatigue after exertion, and were first noticed in the previous February. They became gradually more pronounced, and were supplemented in April by attacks of headache, giddiness, palpitation, and shortness of breath. His appetite, moreover, became exceedingly poor, and he began to experience vague pains, shooting and burning in character, in the region of the stomach. He consulted a medical man and was told that he suffered from indigestion. He accordingly had a course of medicinal treatment; but his condition, instead of improving, grew daily worse, and the weakness became at length most distressing. He continued, however, his employment, and throughout July worked hard at the hay harvest. But the severe manual labour and the heat of summer told so disastrously upon his already enfeebled frame that eventually, in the second week of August, he was obliged to give up work and take to bed. His friends noticed that he was looking worn and ill, and that his face and hands had a peculiar yellowish discolouration. He placed himself a second time under treatment, but his condition showed not the least amelioration. He began in September to suffer frequently from nausea and vomiting. The nausea, though usually worst in the morning, persisted often for an entire day, and prevented him taking a due amount of nourishment; while the vomiting attacks, accompanied as they were by intense retching, left him on each occasion sensibly weaker, and reduced him at last to a condition of extreme prostration. His throat was very sore after the vomiting, and occasionally his sputum would be blood-streaked. He had, moreover, developed latterly a slight cough and become emaciated; but had no diarrhœa, night-sweating, or hæmoptysis. When I saw him on Nov. 28th he was utterly exhausted with the recent and severe vomiting. Although of powerful build and muscular development, he was markedly emaciated, and one could not fail to be struck with the peculiar cachectic appearance he presented. The cheeks were hollow, the eyes sunken, the lips somewhat cyanosed; the ocular conjunctivæ were yellowish and slightly injected, while the skin had a distinctly sallow tinge, which on exposed parts, in the flexures of joints, and in the region of the genitals deepened gradually, though decidedly, into shades of walnut-brown, the hands, axillæ, genitals, and back of the neck being the regions most pigmented, while the scalp, front of the chest, abdomen, legs feet, and mucous membrane of the mouth were apparently unaffected. The discolouration varied much in its intensity in different parts, but was of uniform type and uninterrupted by spots or mottling of any kind. The skin was free from eruption, excess of moisture, and itching; and there was, with the exception of blueness of the lips and faint duskiness and clubbing at the finger-tips, no cyanosis and no œdema. There were no evidences of acute suffering, but the whole attitude and expression of the patient betokened great mental depression and physical exhaustion. He lay in a listless, semi-comatose state, sighing and yawning frequently. He had no appetite, and complained much of thirst, heartburn, flatulence, and pyrosis, with dull aching pain in the epigastrium and feelings of distension and weight about the stomach. He had, moreover, been very sick all the morning, and had vomited all his food a few minutes after taking it, each ejection being accompanied and preceded by intense stomachic pain and retching. Examination of the abdomen threw no light upon the causation of such symptoms. There was, indeed, some tenderness on pressure in the epigastric and hypochondric regions; but no tumour was anywhere discoverable, and the liver and stomach were not enlarged. The bowels were sluggish and the fæcal matter small in amount and pale almost to chalkiness; but neither that nor the vomited matter contained any blood, and the patient did not suffer from hæmorrhoids. There was, however, considerable anæmia. It was unaccompanied by any enlargement of blood glands and was evidently not due to hæmorrhage. The symptoms were headache, giddiness, buzzing in the ears, palpitation, and shortness of breath on exertion. There was a loud hum in the external jugular vein and a systolic murmur in the cardiac pulmonary area. The heart was apparently free from valvular lesion; but the heart sounds, especially the first, were extremely faint. The pulse was regular, moderate in frequency, small in volume, and of low tension. The temperature was subnormal. The urine was clear and straw-coloured, and showed no traces of sugar, albumen, bile, or blood pigments. The patient had a slight cough, with expectoration of scanty, frothy, blood-streaked mucus. The breathing was shallow and the breath sounds almost inaudible. Crepitations, nonconsonating, were audible at the base of each lung, and all over the chest were faint rhonchi, while at the right apex there were a few fine crepitations and a slight prolongation of expiration. There was, however, no dulness or other sign of consolidation. After a careful consideration of the symptoms of the case as a whole, and of the possibility respectively of malignant disease, gastric ulcer, biliary obstruction, chronic phthisis, Bright's disease, and pernicious anæmia, the provisional diagnosis of Addison's disease was made. The prognosis was hopeless, and the treatment, which consisted of milk diet, stimulants, and arsenic, was useless. The patient lingered on for three days, semi-comatose and almost pulseless, and died on the evening of Dec. 1st.

Necropsy on Dec. 4th, 1894. — Putrefaction was just beginning to show itself in green discolouration of the abdomen. Rigidity was present in all the muscles and hypostasis was well marked. The pigmentary changes in the skin of various regions were distinct, more so perhaps than in life. The muscles were much wasted, but there was a fair amount of subcutaneous fat. The heart, which was the first organ examined, was small, pale, and uncontracted, rough and lymph-coated on its epicardiac surface, but inside quite free from endocardiac or valvular disease. The lungs were crepitant throughout and had no morbid excavation or consolidation; but the lower lobes of each lung and the apex of the right were profoundly congested. The stomach was of normal size and contained a little milky food. Its mucous lining was pale, covered with glairy mucus, ecchymosed, and slightly mammillated at the pylorus, but without any signs of ulceration or cicatrices. The intestine, beyond slight congestion of its Peyerian patches and prominence of the solitary follicles, showed nothing abnormal. The spleen was small and shrivelled, and its pulp in a liquid condition; but the liver, gall-bladder, and bile-ducts, with the kidneys and the pancreas, were apparently normal. The adrenals both showed remarkable changes. The right one was, in its lower part, quite hard and calcareous, while the left was represented by a caseous, nodulated, cubical mass two and a half inches in diameter, which on section showed rounded cheesy areas of a yellow colour, separated from one another by bands of darker-coloured fibrous tissue. Each supra-renal mass was perfectly circumscribed, but surrounded by a considerable amount of thickened connective tissue, in which many of the nerve fibres connected with the solar plexus were implicated. No change, however, was observed in the surrounding ganglia or in neighbouring lymph glands.

Barnsley.

A CASE OF RUPTURE OF THE UTERUS OCCURRING AT THE FIRST ONSET OF LABOUR.

BY WM. HARRIS BEST, L.S.A. LOND.

As rupture of the uterus early in labour is of very rare occurrence, I think the following case should be recorded.

The patient, aged thirty-two, mother of seven children, of good physique and accustomed to work hard in household matters, but always having plenty of good nourishment, was attended in her previous confinement by myself, about

eighteen months before the present one. She never had any miscarriage or other symptom of syphilis. I find the following note in my case-book relating to her last confinement: "Long and tedious first and second stages; pelvis roomy; presentation first cranial. Ergot was of decided benefit in arousing uterus to stronger action during second stage. On the fifth day I found on visiting my patient that she was dressed and downstairs, so I immediately ordered her back to bed, where she remained until the tenth day. No ill effects apparently followed this early rising beyond slight increase of discharge. This, her eighth, confinement commenced in the following unusual manner. She and her husband went to bed as usual about 11 P.M., she feeling perfectly well at the time. Very shortly after they had been in bed she said to her husband, 'I believe my confinement is coming on.' A few minutes after that she said, 'I am sure it is so; you had better get up at once.' After he had got up she hurried him off, saying it was coming on quickly. As I was not at home when the message arrived my assistant went immediately. On his arrival he found the nurse there, and was told by her that shortly after the husband had left a smart hæmorrhage had occurred from the vagina; there was ample evidence of this in the condition of the bedclothes near the patient. But one pain occurred and was followed by a gush which she thought was the liquor amnii following the sudden rupture of the membranes. The hæmorrhage ceased when the nurse changed her from the right to the left side; continuous pain was from this time felt on the left side of the abdomen. After waiting about three-quarters of an hour, as labour pains did not come on, I was sent for. On my arrival I found the patient had rather an anxious look on her face. The left-sided pain, though not severe, became so if the abdomen was handled or if she was moved or attempted to move herself. She appeared very nervous and upset, so that it was difficult to tell definitely whether the pain was very acute or the tenderness very great, as she cried out as soon as the vulva was touched in making a vaginal examination. There was practically no collapse, and the depression was only such as might have been produced by a slight hæmorrhage. Her pulse was fairly good, 80 beats to the minute. The patient appeared very much disturbed at the prospect of being touched or examined. The pain was confined to the left side and was not severe, the patient talking in an ordinary way and not complaining unless she attempted to move. On vaginal examination I at first failed to reach the presenting part or, indeed, the os; on inserting the whole hand into the vagina, however, I could get my middle finger inside the os only about one-third of an inch, but felt nothing definite. Though the patient said she had felt movements of the child shortly before labour I could not hear the fœtal heart sounds. Abdominal palpation yielded no definite result as the patient could not bear its being done properly. Nothing definite was thus made out by either examination. The patient now begged to be left alone for a time, and as her pulse remained fairly good and there was but little pain we did so. Neither labour pains nor hæmorrhage occurred for the next hour; her pulse remained about the same, and she became rather more comfortable. At this stage the case looked like either a placenta prævia or slight accidental hæmorrhage, the pulse keeping good, and the patient not complaining of feeling faint or exhausted appeared to place concealed hæmorrhage or ruptured uterus out of the question. As at this time the patient's condition appeared to be improving rather than going back I decided not to use any means for bringing on labour, at least for a time, other than plugging the vagina and orifice of the womb, which latter would answer the double purpose of preventing further external hæmorrhage and keep up a slight reflex stimulation on the womb. This was carefully done with iodoform wool pellets. A few hours after this the patient did not appear to have altered much. She took nourishment and kept it down; her pulse was, however, quicker, her face looked more anxious, and a feeling of sickness was complained of. Her temperature in the mouth was 101°F. I now decided to endeavour to accelerate labour by resorting to more active measures. No hæmorrhage followed the removal of the plugging. On making a vaginal examination a hard indistinctly fluctuating mass was found in front of the anterior vaginal wall and remained after the bladder was emptied. A Barnes' bag was with difficulty passed through the os, the difficulty not arising from the rigidity of the os or any malposition of it, but from its great height. Ergot was given by the mouth freely. No real labour pains followed, though about an hour afterwards the bag was found in the vagina and the os readily admitted two fingers. Still no presenting part could be definitely made out. The next size Barnes' bag was easily passed, and after a time, on its removal, three fingers could easily be passed through the os, and a shoulder was found presenting. Without much difficulty, by means of the bipolar method of version, a foot was brought down into the lowest and posterior part of the uterus. The child was found to be dead, skin peeling off the foot. The passive condition of the uterus during removal of the child was noticeable. No blood or liquor amnii up to this time had escaped. A rupture in the anterior uterine wall could now be detected. The placenta, which was found to be quite free in the uterus, was easily brought away, the uterus remaining flaccid. Hypodermic injections of ether and ergotin were now given, as the patient complained of feeling faint. She quickly revived. The uterus could not be made to contract, though not even an ordinary amount of external hæmorrhage occurred. An iodoform and eucalyptus suppository was left in the upper part of the vagina with its apex passing through the external os, and repeated every six hours. Sickness gradually increased, and the patient died thirty-six hours after the birth of the child with symptoms of peritonitis and exhaustion. No post-mortem examination could be obtained."

The points worthy of particular notice in this case appear to be (1) the very early stage at which rupture occurred; (2) the absence of any other exciting cause than the faulty position of the child (no marked anteversion of the uterus being made out); and (3) the comparative mildness of the first symptoms occurring after so grave an accident.

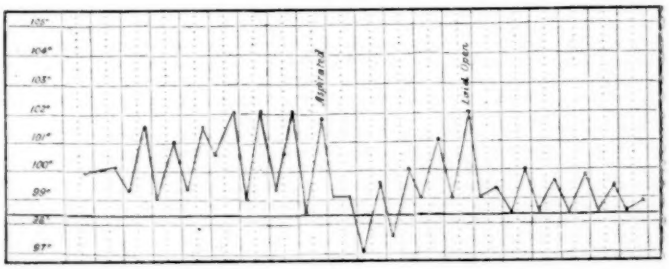
Ilford, Essex.

NOTE ON THE RELATION BETWEEN DYSENTERY AND LIVER ABSCESS.

BY A. W. D. LEAHY, M.D. DURH., F.R.C.S. ENG.,
SURGEON-MAJOR, INDIAN MEDICAL SERVICE.

SOME observers have of late gone the length of denying that any connexion exists between dysentery and abscess of the liver. It is possible, therefore, that notes of the following case may prove of interest to the profession, for I think it demonstrates the connexion which existed between an attack of subacute dysentery and the subsequent formation of an abscess in the right lobe of the liver.

A European male, aged twenty-nine years, was attacked by dysentery on June 18th, 1894. The actual dysenteric attack was comparatively slight in character, confining him to his



bed for five days only; but after the disappearance of the more urgent symptoms he continued to suffer from diarrhœa until the end of July. He was under the treatment of Dr. J. F. P. McConnell and was quite well by July 23rd. On the last day of August, 1894, he began to suffer from fever, his temperature going up to 102°F. in the evening and falling to 99·6° in the morning. To get rid of this fever he went to Darjeeling on Sept. 8th, and returned

thence to Calcutta on Oct. 1st free from fever. The patient consulted me on Oct. 26th for a recurrence of the fever, and, though I carefully examined his liver on that day, there were no physical signs of anything being amiss with the organ. I saw no more of him until Nov. 29th last, when he sent for me, and I found him in bed suffering from great pain in, and with some tenderness of, the hepatic region. His temperature showed a daily rise of from two to three degrees, and never reached the normal limit in the morning. The symptoms during the earlier days of his illness were somewhat masked, but their obscurity gradually cleared up, and on Dec. 12th distinct enlargement with slight bulging of the liver was made out just below the right costal arch. On Dec. 16th this swelling was aspirated and ten ounces of typical hepatic pus were withdrawn. This pus was immediately examined under the microscope by Professor D. D. Cunningham, and was found to contain amœbæ coli in abundance. Four days later the abscess was freely opened and a large drainage-tube inserted. The patient made rapid strides towards recovery, and at the date of writing this the wound in the liver has healed and he is able to take carriage exercise daily. As regards the rapid cure it is needless to say anything, for it is an ordinary successful case of liver abscess treated by free incision and drainage, without washing out the sac with any of the numerous antiseptic solutions. The interest of the case appears to me to lie in the following. A young man, hitherto perfectly well, is attacked by dysentery in the month of June. The dysenteric attack lasts until the latter part of July. In the month of November, after an interval of four months, more or less pyrexial in character, he develops distinct symptoms and physical signs of an abscess in the right lobe of the liver. This abscess is aspirated under precautions that prevent the admission of any air, and the pus thus obtained is immediately subjected to examination under the microscope and found to contain the amœbæ of dysentery. It is known that in cases of dysentery these amœbæ coli are present in the stools and in the walls of the gut which are undergoing dysenteric ulceration. It is also known that one property possessed by these organisms is motility and the power of transporting themselves. May it not then be assumed, looking at this case, that the organisms found in the pus from the liver abscess have had their origin in the previous dysenteric process and have travelled from the ulcerated gut to the liver? Their presence in the liver in this case was a *fact*, and the observation of this one fact is worth many theories. Kartulis, Councilman, and Lafleur have all observed the presence of these amœbæ in cases of abscess of the liver. How the amœbæ get to the liver from the diseased gut must at present be largely a subject for speculation. Do they travel up through clots which block the lumen of vessels opened up by the ulcerative process of dysentery? Or do they reach the liver by way of the lymphatic system? We also know but little as to the part played by them in causing the abscess. They are comparatively large motile bodies, and it cannot be said whether they, by their presence, cause the breaking down of the liver substance, or whether they only act as carriers of some septic poison, which by its irritant properties gives rise to the abscess.

The practical value of the case I have recorded rests, I think, upon three points—viz., (1) the known date of the previous attack of dysentery; (2) the subsequent formation of the abscess in the liver with the pyrexial interval; and (3) the presence in the pus from the abscess of the amœbæ of dysentery. These three points are so closely connected that I think it may safely be affirmed that so-called single tropical abscess of the liver does in some cases owe its existence to a previous attack of dysentery and is due to the amœbæ finding their way from the diseased part to the liver.

Annexed is a chart showing the patient's temperature during the progress of the case.

Calcutta.

FOREIGN UNIVERSITY INTELLIGENCE.—Vienna: Professor Max Gruber, who is already on the Council of Hygiene, has been elected a member of the municipality. Dr. Max Salzmann has been recognised as a *privat-docent* in Ophthalmology. Prague: Professor Wilhelm Czermak has been appointed to the chair of Ophthalmology in succession to Professor Schnabel.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

THE series of cases of diphtheria treated by antitoxin which appear in the subjoined reports form a valuable contribution to the subject, and confirm the opinion that the remedy is one of considerable efficacy. The cases, being all treated in hospital and the diagnosis in each controlled by the bacteriological test, were observed under conditions favourable to the formation of a just appreciation of their character and of the influence of antitoxin upon them. We would draw particular attention to the fact that no less a proportion of the cases reported from University College Hospital than six out of thirteen necessitated tracheotomy, and that of these tracheotomised subjects only one succumbed. Another fact of interest is that of death from suppression of urine after seven weeks' illness in a case of pharyngeal diphtheria, and a clue to this exceptional course is probably afforded by the fact that one of the kidneys was atrophied and cystic. It might be also suggested that the defective renal elimination in this case had some relation to the roseolous rash which appeared on the skin during treatment. In his remarks on these cases it will be seen that Mr. Bunch notes that a rash appeared in three cases, in each case accompanied by a rise in temperature. His suggestion as to the possibility of the fluid containing some impurity is one deserving of the most careful scrutiny. We publish in another column (p. 949) the judgments of several well-known German physicians, and the motion adopted by the Congress of Internal Medicine, meeting now at Munich, on the subject.

UNIVERSITY COLLEGE HOSPITAL.

THIRTEEN CASES OF DIPHTHERIA TREATED WITH ANTITOXIN; REMARKS

(Under the care of Dr. FREDERICK ROBERTS.)

EVIDENCE as to the value of antitoxin in the treatment of diphtheria is being accumulated, and there is no doubt that this remedy has proved successful in many cases. At the recent discussion at the Royal Medical Society of Vienna, Dr. Monti, Dr. Hein, and Dr. Unterholzner gave statistics of eighty-three cases which had been treated by them, with a mortality of only 18·07 per cent. Dr. Kolisko at the same meeting reported that from post-mortem examination of fatal cases in which the serum had been used he had found the membrane much less firmly attached to the mucous membrane than in the fatal cases treated by other methods. Many of the accounts of patients who have died show that they were treated at a late stage; in fact, when almost dying—at a period, in fact, when no improvement could be expected from any treatment. The following thirteen cases of diphtheria were taken into University College Hospital during the months of December and January last, and were all injected with antitoxin within a short time of admission. Of these cases two were fatal—one on the third day through broncho-pneumonia, and the other through suppression of urine after seven weeks' illness. During the same period another case of diphtheria was admitted, but in a moribund condition, the child dying before antitoxin could be injected. Six cases out of the thirteen had tracheotomy performed, and of these one was fatal, the other fatal case being one of pharyngeal diphtheria in which the larynx was not affected. The antitoxin injected was in every case that obtained from the British Institute of Preventive Medicine. The bacteriological examinations were made by Dr. H. R. Smith, Dr. Paul, and Mr. Watts. For the

notes of these cases we are indebted to Mr. J. L. Bunch, house physician.

CASE 1. *Tracheotomy; rash; recovery.*—The patient, a boy aged nine years, was admitted on Dec. 1st, 1894, with dyspnœa and recession, but with no membrane visible in the throat, this being apparently the second day of the illness. Tracheotomy was performed, and 20 c.c. of antitoxin were injected into the lumbar region. On the 2nd the dyspnœa was relieved, but still no membrane could be seen. On the 4th a rubber tube was substituted. On the 16th the temperature rose to 103·2° F.; the child complained of acute pains in the limbs; and a papular eruption appeared on the limbs, trunk, and face. The glands at the angle of the jaw were enlarged, but no joints were swollen. On the 18th the rash had disappeared, and the pain in the limbs diminished, but the breathing became laboured, and a tube had to be inserted again through the tracheotomy wound. On Jan. 7th, 1895, the temperature rose suddenly to 104°, and some fluid was detected in the left knee-joint. The patient was discharged on Jan. 10th without paralysis. No albumen was present at any time, but typical bacilli were found in cultivations from the trachea.

CASE 2. *Tracheotomy; recovery.*—The patient, a girl aged nine years, was admitted on Dec. 8th, 1894, with membrane on both tonsils and on the uvula, this being the third day of illness. Twenty c.c. of antitoxin were injected. On the 9th the membrane had spread to the trachea, and the temperature was 103·6° F. Tracheotomy was performed, and another 10 c.c. of antitoxin were injected. On the 10th the membrane was less, the maximum temperature being 102·2°. A trace of albumen was now present in the urine. On the 11th the membrane was diminished in extent and patchy; the temperature was 101°. On the 16th the membrane disappeared, but there was one-fourth albumen. The temperature was 100°. The patient progressed but slowly and was kept in hospital until Feb. 8th, 1895, her knee-jerks not having returned. On admission diphtheritic bacilli were found in cultivations, but in another cultivation made on Feb. 7th only streptococci, staphylococci, and diplococci were present.

CASE 3. *Tracheotomy; erythematous rash; recovery.*—The patient, aged five years, was admitted on Dec. 19th, 1894, with membrane on both tonsils and stridulous breathing. Twenty c.c. of antitoxin were immediately injected, and tracheotomy was performed later in the day. On the 20th the child was breathing quietly, and the temperature had fallen from 102° to 100·6° F. On the 21st no membrane was present in the throat, but the tonsils were raw and bleeding. On the 27th an erythematous rash appeared on the forearms and chest, but there were no pains in the limbs. On Jan. 2nd, 1895, a diffuse rash came out all over the body, accompanied by a slight rise of temperature. On the 4th the rash had disappeared. The patient was discharged on Jan. 12th quite well. Cultivations showed typical bacilli. A slight trace of albumen was present.

CASE 4. *Pharyngeal diphtheria; recovery.*—The patient, aged six years, was admitted on Dec. 17th, 1894, on the third day of illness, with membrane on both the tonsils and soft palate. Twenty c.c. of antitoxin were injected. On the 18th the membrane had not diminished, and another 10 c.c. of antitoxin were injected. Some albumen was present. The temperature was 102° F. The membrane decreased slowly until the 27th, when it disappeared. The patient was discharged on Jan. 7th, 1895, without any paralysis, but a faint cloud of albumen. Cultivations showed diphtheritic bacilli.

CASE 5. *Nasal and pharyngeal diphtheria; recovery.*—The patient, aged two and a half years, was admitted on Dec. 20th, 1894, after two days' illness. Membrane was present on both tonsils, and there was a discharge from the nose. Twenty c.c. of antitoxin were injected. On the 21st the nasal douche brought away casts of the turbinate bones. Membrane was still present on the 23rd, and another 5 c.c. of antitoxin were injected. This was followed by disappearance of the membrane on the 24th, and of the swelling around the angle of the jaw. The patient was discharged on Jan. 5th, 1895, quite well, but a cultivation was made from his throat on Feb. 16th. This showed a complete absence of the diphtheritic bacilli, which were abundantly present on admission.

CASE 6. *Pharyngeal diphtheria; erythematous rash; suppression of urine; death after seven weeks.*—The patient, a girl aged four and a half years, was admitted on Dec. 23rd, 1894, after two days' illness. She was the sister of the last-mentioned patient. She had membrane on both tonsils and on the soft palate; the temperature was 103·2° F., but there was no albumen in the urine; 20 c.c. of antitoxin were injected during the course of the day. Cultivations from the throat showed numerous bacilli diphtheriæ. On the 24th there was still a good deal of membrane, but the highest temperature was 101·6°. On the 28th membrane was still present, and nasal douches brought away a large piece of membrane. There was one-eighth albumen. On Jan. 1st, 1895, a diffuse red rash came out over the body, and the temperature rose in the evening to 102°. There were no pains in the limbs. There was one-fifth albumen in the urine. On the 8th no membrane was to be seen. The urine seemed scanty, and when measured was found to be only six ounces during the previous twenty-four hours. There was one-fifth albumen in the urine. The latter was secreted only in small amount from now until the patient's death, not exceeding twelve ounces in any one twenty-four hour period. The albumen gradually decreased, and by Jan. 23rd had entirely disappeared. The child seemed to be fairly well in herself, but was kept in bed, as no knee-jerks were obtainable and the palate moved badly. On Feb. 6th she had an attack of dyspnœa and became cyanosed, having passed only three ounces of urine during the previous twenty-four hours. There was now so much difficulty in swallowing that she had to be fed with a nasal tube. On the 8th, while being fed with the nasal tube, she died suddenly. The amount of urine passed in twenty-four hours for the last few days of life was as follows: Jan. 29th, 9 oz.; 30th, 10 oz.; Feb. 1st, 8 oz.; 2nd, 7 oz.; 4th, 5 oz.; 5th, 6 oz.; 6th, 3 oz.; and 7th, 6 oz. At the necropsy Dr. Poore found the right kidney to be large and congested, weighing three ounces; the left kidney was small, cystic, and weighed only half an ounce. Dr. Sidney Martin found degeneration of all the peripheral nerves examined, both sensory and motor.

CASE 7. *Tracheotomy; broncho-pneumonia; death.*—The patient, aged one year and a half, was admitted on Dec. 21st, 1894, with considerable recession, being obviously very ill. This was stated to be the fourth day of illness. Tracheotomy was performed. On the next day there was no change for the better, and 20 c.c. of antitoxin were injected. On the 23rd the child was cyanosed, breathing rapidly and shallowly, and râles were heard all over the chest. Another 5 c.c. of antitoxin were injected, but the patient never rallied and died the same morning. At the necropsy membrane was found to have extended into the second bronchial ramifications, and broncho-pneumonia was present. Cultivations showed numerous bacilli.

CASE 8. *Pharyngeal diphtheria; recovery.*—The patient, aged six and a half years, was admitted on Jan. 2nd, 1895, with membrane on both tonsils and on the soft palate, and one-third albumen in the urine; 10 c.c. of antitoxin were injected. The membrane was less next day, and so was the albumen, and on Jan. 4th no membrane was to be seen. On Feb. 16th the knee jerks were still absent. Typical bacilli were found in cultivations.

CASE 9. *Pharyngeal diphtheria; recovery.*—The patient, aged thirty years, was admitted on Dec. 30th, 1894, after three days' illness, with membrane on both tonsils and on the uvula. Fifteen c.c. of antitoxin were injected. The membrane gradually diminished and had disappeared by Jan. 2nd, 1895. No paralysis supervened.

CASE 10. *Tracheotomy; recovery.*—The patient, aged one year and a half, was admitted on Jan 15th, 1895, with considerable recession, but no visible membrane. Tracheotomy was performed, and 15 c.c. of antitoxin were injected. On the 16th the temperature was 104° F., but the breathing was much relieved. On the 17th the temperature fell to 100·4°; some amount of bronchitis was present. Improvement was uninterrupted until Feb. 4th, when the patient was discharged. No albumen was detected at any time, and no paralysis supervened. Numerous typical bacilli were found.

CASE 11. *Pharyngeal diphtheria; recovery.*—The patient, a man aged twenty years, was admitted on Jan. 23rd, 1895, with membrane on one tonsil and on the uvula, and a trace of albumen in the urine; 18 c.c. of antitoxin were injected into the subcutaneous tissue of the abdominal wall. On the 24th the membrane was more patchy, less in amount, and less firmly adherent to the tonsils. The tonsils were, however, swollen, inflamed, and in places appeared to be ulcerated. The patient seemed to be pretty well in himself, though rather pale and anæmic. On the 26th no membrane was to be seen. He was discharged on Feb. 4th without any paralysis or other sequelæ. Cultivations on blood serum showed colonies of diphtheritic bacilli and some cocci.

CASE 12. *Tracheotomy; some paralysis when discharged.*—The patient, aged two and a half years, was admitted on

Jan. 6th, 1895, after a week's illness, with membrane on both tonsils and in the trachea. Tracheotomy was immediately performed, and 10 c.c. of antitoxin were injected. The temperature rose to 102·4° F. during the night, but there was less membrane to be seen next day. The urine contained one-half albumen; 8 c.c. of antitoxin were again injected. On the 9th another 5 c.c. of antitoxin were injected, the temperature being 101·6°. The membrane gradually diminished and finally disappeared by the 11th; there was now only a trace of albumen. Considerable difficulty was experienced in trying to do without the tracheotomy tube, and it could not be left out altogether until the 22nd. The patient was discharged on Feb. 8th with weakness of the right side and the knee-jerks absent, but was readmitted on the 13th under the care of Dr. Poore with lobar pneumonia. Numerous bacilli were found soon after his admission.

CASE 13. *Pharyngeal diphtheria; slight paralysis.*—The patient, aged ten years, was admitted on Jan. 29th, 1895, with membrane on both tonsils and on the uvula, and a trace of albumen in the urine, having been ill three days; 10 c.c. of antitoxin were injected, and again 10 c.c. next day (the 30th). The throat cleared up gradually, and by Feb. 4th no membrane could be seen. The knee-jerks were absent from an early stage of the illness, and were still absent on March 1st. Diphtheritic bacilli were found in cultivations.

Remarks by Mr. BUNCH.—The percentage of deaths (15·4) in this series of cases is considerably below the average of deaths from diphtheria, and even of those cases previously treated with antitoxin in University College Hospital. The number of cases is, of course, too small to afford statistics of value, but it may certainly be said that the cases were at least of average severity. The antitoxin previously used in University College Hospital was obtained from a different source to the Institute of Preventive Medicine, but the objection urged against the latter that the injections are rather bulky was found in practice to be of little weight, for the swelling soon subsided, and in no case was inflammation set up around the point of injection. There was, however, some amount of tenderness, varying with the age of the patient. The three cases in which a rash appeared after the injection of antitoxin are of interest, for in every case the eruption was accompanied by a rise of temperature, and in one case by rather severe pains in the limbs, causing the child to cry out with pain. In this case the rash appeared fifteen days after injection, and presented an appearance markedly resembling that of rötheln. In another case the rash came out nine days after injection, and was more of an erythematous character. In another child a rash appeared twice with an interval of six days, the first time eight days after injection. It seems possible that some impurity or septic material was contained in the fluid injected, for the strictest antiseptic precautions were taken to sterilise the syringe and needle, and disinfect the skin. Two of the cases which thus developed a rash progressed very slowly, and one eventually died from suppression of urine. Though the total number of deaths was so small, it could not be said that the membrane disappeared immediately after antitoxin had been injected, or even that the albumen always diminished, for in one case membrane was seen fifteen days after the first injection, and albumen appeared in the urine a few days after the injection, though none was present on admission. One of the children on whom tracheotomy was performed was only one and a half years old, but she stood the operation well, and recovered rapidly.

BROMLEY AND BECKENHAM FEVER HOSPITAL.

THREE CASES OF DIPHTHERIA TREATED WITH ANTITOXIN SERUM; TRACHEOTOMY PERFORMED IN TWO OF THE CASES; RECOVERY IN ALL.

(Under the care of Dr. G. W. DAVIS and Mr. R. A. SHANNON.)

WE are hearing much more hopeful accounts of the results of tracheotomy and intubation in diphtheria under the antitoxin treatment in our large hospitals than was the case a few months ago, but we cannot at present furnish statistics on this point. The communication to the Société Médicale des Hôpitaux of MM. Lebreton and Magdelaine, besides furnishing evidence of the general value of the remedy when used by them at the Hôpital des Enfants Malades, gives also some account of the results obtained when it was necessary to perform one of these operations. Two hundred and fifty cases were treated by the antitoxin treatment in a period of three months, with a mortality of 9·2 per cent. After tracheotomy (the cases requiring it are always serious) there was a mortality of 37·5 per cent. After intubation the mortality was 15·9 per cent. when those dying within twenty-four hours after admission from lung complications or general intoxication were deducted. The three cases here reported were all of them affected with undoubted diphtheria, proved by bacteriological investigation in one of the cases, and clinically evident in the other two. Mr. Shannon and Dr. Davis believed that not one of the cases would have recovered but for the use of antitoxin.

CASE 1.—A male child, eighteen months old, was first seen at midday on Oct. 17th, 1894. The infant was suffering from diphtheritic sloughs on both tonsils, croupy cough, and inspiratory retraction of the intercostal spaces and ensiform cartilage; the temperature was 102° F. (The Clinical Research Association confirmed the diagnosis by telegram on the 18th: "Many Klebs-Löffler bacilli.") At 12.30 P.M. seven minims of Aronson's antitoxin were injected into the left forearm. At 4 P.M. the arm was swollen and red. The cough was very croupy in character; the child refused all food. There was marked retraction of the supra-clavicular and infra-clavicular area in inspiration. At 10 P.M. the retraction was more marked. There was retraction of the entire sternum in forced inspiration. A second fifteen minims of antitoxin were injected into the right forearm. On the 18th, assisted by the parish nurse, Dr. Davis administered chloroform and performed tracheotomy at 1 A.M. At 10 A.M. the child breathed easily. The tube was cleaned every two hours. At about 6 A.M. the patient became very collapsed, but rallied. At 12 (midday) there was abundant membrane in the tube: one pint of milk had been taken since the operation. On account of the offensive character of the stools three grains of calomel was ordered. At 4 P.M. the tube, nearly choked with membrane, was difficult to clear. The child took milk well. The wound was becoming sloughy. At 8 P.M. he was pale and ceased to care for his milk; the membrane was increasing in quantity, and the temperature was 100·8°. A third fifteen minims of antitoxin were injected into the left forearm. On the 19th sixteen ounces of milk had been taken during the night. From this time the child passed from Dr. Davis's care to that of Mr. R. A. Shannon of the Bromley and Beckenham Joint Fever Hospital. On the 23th it was necessary to clean the cannula every two hours night and day; the whole tube was removed every day, but great embarrassment and lividity occurred, so that it had to be replaced. The membrane from the cannula was sent to the Clinical Research Association, and the following report was received: "No bacillus diphtheriæ; numerous streptococci and staphylococci." On the 30th a soft rubber tube was substituted for the silver one. A drop or two of a solution of menthol in olive oil (two grains to the ounce) was introduced into the tube every half hour, after the suggestion of Dr. Roux. Very severe coughing followed upon the introduction of the rubber tube. At 4 A.M. on Nov. 2nd the matron was urgently called by the night nurse, and found the child apparently dead and cold. The tube had been coughed out, one of the eyelet holes for the tape having split. With commendable presence of mind she replaced the tube and performed artificial respiration, and had the satisfaction of seeing the child revive. The tube was held in place until another could be obtained. On the 8th a fenestrated rubber tube was substituted. On the 17th the child was quite well, but it was found impossible to do without the tube. The child was discharged wearing the tube, in the hope that after remaining some days at home he might be removed to a general hospital. The air of a poor and crowded home set up symptoms which threatened septic pneumonia, so that on Nov. 21st Dr. Davis sent him to St. Thomas's Hospital, asking if he could be admitted and an endeavour made to wean him of the tube; this was done, and he was discharged cured on Jan. 11th without the tube. Whilst at St. Thomas's Hospital a second tracheotomy was performed below the first, and the trachea above dilated.

CASE 2.—On Nov. 13th, 1894, a girl four years of age was admitted into the Bromley and Beckenham Fever Hospital with severe diphtheritic involvement of the fauces and tonsils, the glands about the angle of the jaw were involved on either side, and the involvement of the trachea was marked with loss of voice and a very bad croupy cough, associated with marked inspiratory retraction. On the 15th the case was one of extreme gravity; the child was voiceless, with a dull,

opaque, bluish-white complexion, was unable to take any nourishment, and from time to time vomited; there were also attacks from time to time of such severe dyspnœa that the case looked extremely hopeless. Under these circumstances Messrs. Shannon and Yolland, medical officers of the hospital, invited Dr. Davis to a consultation on the case, and it was the unanimous opinion that tracheotomy was the only chance. Dr. Davis, having the instruments at hand, was invited to operate, and tracheotomy was performed. He supplied some of Aronson's antitoxin to Mr. Shannon, who injected it as follows: at 4 P.M. on the 15th fifteen minims of antitoxin were injected; at 4 P.M. on the 16th ten minims of antitoxin were injected; at 10.30 A.M. on the 18th eight minims of antitoxin were injected, and fifteen minims at 4 P.M. The rule was adopted to inject every six hours so long as the temperature remained above 100° F. On the 27th the tube was finally removed, and the child was discharged cured on Dec. 8th, 1894.

CASE 3.—A male child eight years of age was seen by Dr. Davis during the afternoon and in the evening of Nov. 20th, 1894. The case was considered from the first to be very grave. The temperature was 102 4° F., the tonsils and fauces were covered with membrane, which had involved the trachea, so that the boy could scarcely utter a sound, and the inspiratory retraction was very marked. The case appeared to be quite hopeless without recourse to tracheotomy, but the parents would not consent to this. At 7 P.M. Dr. Davis injected twenty minims of antitoxin into the left forearm, and the next morning the boy was removed to the Bromley and Beckenham Fever Hospital and was discharged as cured on Dec. 8th. It should be added that, although the evidence clinically in this case was to us both conclusive, the Clinical Research Association reported upon the culture box which Dr. Davis sent as follows: "Evidence of diphtheria probable, not certain. The appearance of the culture is not suggestive of diphtheria. The culture consists: (1) of staphylococci; (2) of larger cocci, probably pneumococci; (3) of a minute bacillus; and (4) of a very few somewhat large bacilli, suggesting degenerate bacillus diphtheriæ."

Remarks by Dr. DAVIS.—The three cases were all partly under my care and under that of Mr. Shannon when they were in the Bromley and Beckenham Fever Hospital. Concerning Case 1 I have suggested to a manufacturer that for the future it would be well that the shield of rubber tubes should be backed throughout with canvas; at present that part of the shield perforated with holes for the tape is not so backed. In the diagnosis of diphtheria I should be inclined to use bacteriological evidence as affirmative, but not as of negative value in cases in which the clinical aspect of the case pointed to diphtheria. Bryant's tubes were those used in the tracheotomies.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Case of Large Pelvic Hydatid successfully treated by Perineal Incision and Drainage.

AN ordinary meeting of this society was held on April 9th, the President, Mr. HUTCHINSON, being in the chair.

Mr. REGINALD HARRISON described a case of Large Pelvic Hydatid successfully treated by Perineal Incision and Drainage. The patient, a physically fine and otherwise healthy man, aged forty-five years, had never suffered any illness before the present. Nine years ago he began to have trouble about the bladder and rectum. This increased to such an extent that he was compelled to resort to large doses of morphia for relief and was disabled from work. In 1893 he left Australia and came to London. Mr. Harrison saw him shortly after his arrival, at the suggestion of Dr. Batten. There was a very large tumour occupying the pelvis and lower part of the abdomen, extending almost to the umbilicus. The pain and difficulty about passing water and motions were excessive. Careful examination and the history led to the conclusion that the tumour consisted of one or more hydatid cysts. In October, 1894, an incision was made through the perineum corresponding with a lateral lithotomy, but without opening the urethra. The cyst was reached, and about half a gallon of fluid and cysts was evacuated. The cavity was washed out and drained. The greatest relief was experienced. The cavity gradually contracted and the wound healed. The patient was now in perfect health. The question for consideration in the case of such like pelvic hydatids was as to where the opening should be made—whether through the abdominal wall, through the rectum, or by incision through the perineum, as in the case related. The last method was considered to be the best.

Dr. JOHN HARLEY remarked that in the forty-ninth volume of the Society's Transactions he had brought together over 100 cases of hydatid tumour with a view to prove the futility of simple puncture in these cases, a method which was likely to be adopted by physicians. In the St. Thomas's Hospital Reports he had collected a further 96 cases, and all went to show that a radical cure of a hydatid cyst could not be effected without the discharge of the parent cyst, and the healing of the cavity left after its removal. Puncture was often followed by shrinkage, suggestive of cure, but later either suppuration might occur of slow contraction with all its attendant troubles.

Mr. DURHAM said that hydatids of the abdomen and pelvis were common, but cases precisely like the one previously reported were rare, and successful treatment of them was still more rare. In the case described the hydatid was fixed in the fibrous tissues between the bladder and the rectum, and was not movable, like most abdominal hydatids, except those of the liver. He referred to a case which was admitted into Guy's Hospital under his care with intestinal obstruction and difficulty in passing water. An exploratory operation was undertaken to discover the nature of the trouble, and on opening the abdomen a hydatid cyst was discovered fixed in the pelvis. He opened the cyst, evacuated its contents, and stitched the cyst wall to the abdominal wall. The patient died four days afterwards of acute peritonitis, and at the necropsy a condition was found apparently much like that in Mr. Harrison's case.

Mr. WARRINGTON HAWARD said that a complete cure depended upon the completeness of the evacuation of the cyst. He could not help thinking that in some cases of pelvic hydatids drainage would be very difficult from the perineum. He had to treat a case of pelvic hydatid a few years ago, in which he was able to be confident of the diagnosis because another hydatid cyst existed higher up in the abdomen. In that case he hoped that a complete removal of the pelvic hydatid would have been possible, but the lower part of the cyst was intimately connected with the bladder and rectum, and its pressure on the former viscus had caused retention of urine. If a pelvic hydatid projected up into the abdominal cavity it was better to open the peritoneum and stitch the cyst to the abdominal wall; there would then be no difficulty about cleansing the abdominal cavity and drainage; besides, the abdominal section would render it possible to decide whether other hydatid cysts were present or whether the cyst itself was removable, as in a case recorded by Mr. Jonathan Hutchinson, jun.

Mr. TARGETT gave the reasons which induced him to regard all these cysts as having their origin between the muscular coat of the bladder and the sheath of the recto-vesical fascia. By dissection of all available specimens he had shown that the cysts lay in this position, and in certain dry specimens the vasa deferentia were seen to be separated from the bladder by the cyst. By experiment he had found that it was easy to make such a separation; the finger easily separating the fascial sheath from the vesical muscular wall. In certain cystic protrusions and malignant growths of the bladder developing backwards there was a similar disturbance of the relation of the vasa deferentia to the bladder wall. Hydatid cysts could not arise secondarily in this position. They might rarely begin, as Dr. Fagge had described, by falling into the pelvic cavity after perforating the walls of the stomach, but this method of origin must be very rare. In the cysts which arose under the pelvic fascia the embryos were deposited from the venous plexuses, and the same thing was true with regard to hydatids of bone; they were usually found in the cancellous ends of long bones or in the vertebræ. In bone they were commonly primary, and were often the only hydatid deposit in the body. In Mr. Hunter's case the bladder projected eight inches above the pubes, and a recent dissection showed it to bear the same relations to the vesiculæ seminales as the other specimens referred to.

The PRESIDENT said that some years ago he had published several cases in which recovery resulted from a single aspiration. One such case of hepatic hydatid he some years later

had to treat by evacuation. At the present time he was prepared to agree generally that evacuation should be practised whenever the cyst was large or the hydatid dead. He had seen several instances in which hydatids were passed by the urine.

Mr. HARRISON, in reply, said that the question whether abdominal section should be performed was carefully weighed. The length of time which the cyst had lasted, the downward pressure which it had exerted, and the ease with which the dependent portion of the cyst could be reached, led him to the conclusion that the perineal method was the best.

MEDICAL SOCIETY OF LONDON.

Congenital Chorea. — Facial Hemiatrophy. — Friedreich's Disease.—Case after Removal of a Papilloma of the Bladder by Suprapubic Cystotomy.—Syphilitic Disease of both Knee-joints.—Large Renal Sarcoma from Child aged Three Years.—Subcutaneous Nodules in an Infant.—Devergie's Pityriasis Rubra Pilaris.—Rudimentary Ear.—Macrocheilia.—Restoration of Nose by means of Transplanting part of Middle Finger of Left Hand.

AN ordinary meeting of this society, devoted to the exhibition of clinical cases, was held on April 8th, the President, Sir WILLIAM DALBY, being in the chair.

Dr. G. JOHNSTON showed a boy aged twelve the subject of Congenital Chorea. He was born at term, the labour being natural, and the movements had continued ever since, involving the arms, legs, and face, and occasionally he had long shivering inspirations. The movements, though bilateral, were most marked on the left side; they ceased during sleep. There had been no fits and no rigidity, and the deep reflexes were brisk but not exaggerated.—Dr. A. GARROD said that he had a case under his care which precisely resembled the case shown. In his patient there was feeble mental development, but the child was by no means an idiot.—Dr. SHUTTLEWORTH said that the case was interesting because, together with the chorea, there were athetotic movements suggestive of lesion of the Rolandic area; the boy was nevertheless free from spastic rigidity. The London School Board had established several centres where children of this class could be trained.

Dr. BEEVOR showed a case of Right Facial Hemiatrophy in a girl aged twenty in whom there was no family or previous history of importance. Two years ago two teeth in the right upper jaw decayed and broke away, and six months later, without any injury, she noticed a dimple in the right cheek, which had gradually increased till now. There was marked thinning of the cheek, with falling in of that side, the measurement from the middle line of the upper lip to the meatus auditorius externus being a quarter of an inch less on the right side. The muscles of the face and for mastication were normal, and reacted to faradisation; in fact, the former reacted to a weaker current on the right than on the left side. The tongue and soft palate were normal. The bones of the face and the nasal cartilages were not affected. Sensation to touch, pain, heat and cold was normal. Taste was not affected. The disease was considered to be in the trophic fibres of the fifth nerve, which, according to Mendel, were in the upper root of this nerve.

Dr. LEONARD GUTHRIE showed a boy aged nine years who presented early symptoms of Friedreich's Disease. There was no family history of the complaint. The symptoms dated from his learning to walk at the age of three. They were: (1) unsteadiness on standing markedly increased when the eyes were closed and the heels kept together; (2) a reeling gait and inability to "toe a plank"; (3) slight rhythmical tremors affecting the whole body and increased on exertion; (4) slight incoördination of the hands in executing fine movements; (5) complete absence of knee-jerks. Sensation was everywhere normal. Muscular sense was unimpaired. There were no ocular symptoms and no deformities. Speech and intelligence were unaffected. The sphincters acted normally. No definite tabetic pains had occurred. Headache and vomiting were absent. He had been under observation for four months, and the symptoms were slightly on the increase. The differential diagnosis of the case was discussed. Dr. HECTOR MACKENZIE said he had exhibited a similar case which was an isolated one, no other member of the family being attacked.—Dr. ORMEROD said that it was probably a case of Friedreich's disease, although it appeared to be diagnosed by two symptoms only—namely, a peculiar gait and absence of knee-jerk. Other symptoms described in Friedreich's original cases were absent, such as peculiar speech, nystagmus, and family proclivity.—Dr. BEEVOR agreed in the diagnosis and said that these cases were now recognised much earlier than they used to be.—Dr. COLMAN remarked that two other symptoms were present—a general tremor of the trunk when at rest and slow nodding movements of the head and trunk.

Mr. SWINFORD EDWARDS showed a case after Excision of a Papilloma from the Bladder. The patient was a man aged fifty-four, who had suffered from intermittent hæmaturia commencing three months ago; there was also right lumbar pain. The growth was removed by suprapubic cystotomy and the wound had quite healed.

Mr. WARING showed a woman forty-five years of age who first presented herself to him with Syphilitic Disease of both Knee-joints. Later she returned to the hospital, and an affection of the knee-joints was found similar to that seen in Charcot's disease. There was marked swelling, especially of the right knee, but the knee-jerks were exaggerated. There was increased vesical irritability. The syphilis had been acquired ten years previously, and had been treated with iodide of potassium, but not with mercury.

Mr. HERBERT ALLINGHAM showed a Renal Tumour weighing two and a half pounds which he had removed from the right side of a child aged three years. The child was at the present time in good health. He stated that the growth had not at present been examined microscopically. It arose from the capsule of the kidney, and the supra-renal body was free. There were no urinary symptoms and the ureter was dropped back after ligation.

Dr. ABRAHAM showed a female infant who for ten weeks had suffered from Multiple Subcutaneous Nodules. The larger ones had become directly connected with the skin, and fluctuated. They were scattered all over the body. He thought that they were multiple tuberculous granulomata.—Mr. LEOPOLD HUDSON said that he had seen three very similar cases within the last eighteen months at the Hospital for Sick Children. The last, sent him by his colleague Dr. A. Garrod, was associated, like the case shown, with a bad attack of thrush. The multiple lesions proved on exploration to be abscesses, and their evacuation was followed by a rapid convalescence.

Dr. ABRAHAM showed a boy aged six years who was the subject of Pityriasis Rubra Pilaris. The present attack had developed within three weeks. Such cases were rarely seen in children; the boy had had a similar attack two years ago, and had got well. The affection was of the xerodermic type.

Mr. ASTLEY BLOXAM showed a child sixteen months of age with a Rudimentary Ear on the right side. There was also a dimple between the angle of the jaw and the mouth.—Sir WILLIAM DALBY said that he had seen a number of these cases. Sometimes there were as many as three rudimentary ears on the same side. Occasionally in such cases as that shown there was imperfect development of the labyrinth on the opposite side.

Mr. BLOXAM then showed a girl aged twelve who had a Deformity of the Chin, which had existed from birth. It involved the cheek to a slight extent, and consisted of some dilated lymphatics with enlarged bloodvessels as well. He proposed to dissect it out.

Mr. BLOXAM lastly showed a middle-aged man whose Nose had been destroyed by Tertiary Syphilitic Disease. An attempt had been made at Netley to form a new nose from the skin of the forehead, but this had not been very successful. An amputated child's finger was then attached to the part, but this refused to adhere. The middle finger of the man's left hand was stiff and useless to him, so an incision was made down its anterior surface and the tendons dissected out. The finger was then attached in the position of the nose, the arm being supported by plaster of Paris. Later the soft tissues at the root of the finger were divided on each side by the actual cautery and the bone divided, the distal phalanx with the nail having been previously removed. The ultimate result was the formation of a very presentable nasal organ, an ala on each side being subsequently fashioned from the tissues of the cheek.

OBSTETRICAL SOCIETY OF LONDON.

Temperature, Pulse, and Respiration during Labour and Lying-in.—Ovariotomy in Women over the age of Eighty Years.—Exhibition of Specimens.

A MEETING of this society was held on April 3rd, Dr. F. H. CHAMPNEYS, President, being in the chair.

The following abstract of a paper by Dr. PROBYN-WILLIAMS and Mr. LENNARD CUTLER upon Temperature, Pulse, and Respiration during Labour and Lying-in was read. The writers first considered the effect of labour. With regard to temperature they find that their results coincide with those of Dr. Giles. With regard to pulse they find: 1. *Rate:* The low rate of the pulse after delivery, as given in the text-books, is exaggerated. In one hundred cases of normal labour observed in connexion with this point they found that in 76 the rate was diminished, in 11 it remained stationary, and in 13 it was increased after the end of the third stage. In this series the average decrease between the rates during the first stage, and half an hour after the end of the third, was eleven beats per minute (from eighty-nine in the first stage to seventy-eight after delivery). Parity and the length of labour have some influence on this fall; and after the administration of chloroform during labour it is common to find the pulse remaining high after delivery. In 19 cases of post-partum hæmorrhage there was an average *rise* of nineteen beats per minute (seventy-eight during labour, ninety-seven after delivery). 2. *Tension:* This, as estimated by tracings made with Dudgeon's sphygmograph, is usually above normal during labour, but is occasionally low, notably in one case in which delivery was followed by considerable hæmorrhage. *Respiration.*—After delivery there was on the average a fall of one respiration per minute (23 during labour, 22 after delivery). After the administration of chloroform this decrease was not observed. The effects observed in connexion with lying-in were as follows:—*Temperature.*—The average temperature of 100 cases varied between 98° and 99°F., being higher in the evening than in the morning. The highest average temperature was reached on the first day and was higher in primiparæ than in multiparæ. Rupture of the perineum had no appreciable effect on the temperature during the puerperium. *Pulse.*—(1) Rate. The writers do not agree with the statements in the text-books that the pulse is normally very slow during the first week, but found that the average rate of 100 cases was never lower than 72. The pulse-rate was faster in the morning than in the evening throughout this series. (2) Tension. In a few cases the tension is diminished by delivery; but in the majority it is increased. Whatever may be the tension of the artery during labour, and whether it rise or fall after delivery, within twenty-four hours it has always increased so much that it is at least as great as, and generally greater than, the tension during labour. This increased tension may persist throughout the puerperium, and commonly lasts longer in multiparæ than in primiparæ. *Respiration.*—The rate of respiration was found to vary between twenty and twenty-two per minute. It tends to follow the pulse-rate in being higher in the morning, and not the temperature, which is higher in the evening.—Dr. DAKIN congratulated Dr. Probyn-Williams and Mr. Lennard Cutler on their very important paper. Their observations on the temperature, which were made under circumstances most favourable for accuracy, showed what was the typical chart of a lying-in woman—namely, one differing in no way, except for some slight exaggeration of the evening rise and morning fall, from that of a person in ordinary health. The chart of the cases where perineal rupture was present showed the efficacy of the antiseptic methods in use at the General Lying-in Hospital at the present time, for it did not differ practically from that of cases where there was no rupture. The pulse-rate which they found to be the average was perhaps more interesting, as it was opposed in some degree to what was stated in the text-books. Their results were, however, what most of those who had large experience of lying-in women would expect. As regarded the tension of the pulse, they again were at variance with what had been hitherto accepted. Fritsch and Meyburg found that the tension was diminished; and it became difficult to reconcile this with the slower rate. Dr. Probyn-Williams and Mr. Cutler's results showed that the pulse obeyed the ordinary laws of the circulation in these circumstances, and explained the tendency to a slow pulse by the high tension always present. Their results explained also the frequency of pulse which often preceded post-partum hæmorrhage, if it were assumed, as it fairly might be, that the suddenly increased arterial tension which normally occurred was due to a retraction of the vessels in unison with the retraction of the uterus. Then, if retraction of neither uterus nor arteries were complete, there would be, as happened in the cases in the paper, a low tension and rapid pulse on the one hand and a relaxed and bleeding uterus on the other. It is possible that the increased rapidity observed by Dr. Probyn-Williams and Mr. Cutler after the administration of chloroform was due to diminished tension, and the tendency to post-partum hæmorrhage, believed by some to exist in women who have had chloroform during their labour, might be thus explained. Dr. Dakin had never seen this effect from the drug. One effect of its administration was that the child at birth was often very lethargic, and did not begin to cry vigorously at once without considerable stimulation.—Dr. REMFRY considered that the rise in pulse-rate after chloroform might be due to the fact that in the cases recorded chloroform had only been given in tedious labours and when instrumental or other manipulations had been necessary.—Dr. HORROCKS thought the increased rate of the pulse in post-partum, as in any other form of hæmorrhage, was physiological. Theoretically, half the amount of blood in the body could do the same work in a given time if it were circulated with double the velocity. The increase in number of heart beats was an attempt to increase this velocity *pari passu* with the loss. The precise way in which the loss of blood set up the increased rate was not perhaps known, but no doubt it was through the vaso-motor system. He could not agree with Dr. Dakin regarding retraction of the heart and arteries. As a matter of fact, so long as the heart was completely refilled with blood there was no retraction. If it were under-filled there would be some retraction, and if it were not refilled at all there would be complete retraction during each diastole. The increased size of the left ventricle during pregnancy was a hypertrophy, and its subsequent diminution was an involution.—Dr. AMAND ROUTH asked for more information as to the effect of chloroform upon the temperature of the lying-in woman. He thought the administration of chloroform by lowering the heat of the body might in a measure account for the difficulty in reviving children after its use, which, as Dr. Dakin had stated, was not infrequently observed.—Dr. DUNCAN agreed with Dr. Probyn-Williams and Mr. Cutler in questioning the accuracy of the statement made in text-books that the pulse-rate became slower after delivery. In years gone by he (Dr. Duncan) used to dread post-partum hæmorrhage if the pulse kept up to 110; but he found his fears were groundless, as he had never had a case of this accident, whilst a good many of his patients had a pulse of over 100 for some hours after delivery. He thought a high pulse-rate was met with most often in the upper classes of society, where a neurotic temperament was not rare.—The PRESIDENT said that a paper of this kind was much needed to test and correct accepted views, which were apt to be quoted from book to book without sifting. The chief point in debate seemed to be the pulse. In his experience this was often rapid, especially after excitement, either mental or bodily, without any undue loss of blood. But in this case the beats were distinct and the tension good. The pulse of hæmorrhage was running, the beats not well separated, and the tension low. Such a pulse often preceded hæmorrhage and betokened a general vaso-motor condition affecting the heart, arteries, and uterus.

Dr. LEONARD REMFRY read a paper on Ovariotomy in Women over the Age of Eighty Years. Ten cases were recorded, all of whom had recovered. The list included operations in England, America, Australia, and Germany. One patient, aged eighty-three years, suffered also from epithelioma of the vulva. Dr. Remfry saw her in August, 1894, and the epithelioma was at once freely removed. In November there were no signs of recurrence, and, the internal tumour being larger, ovariotomy was performed; her convalescence was satisfactory. The paper concluded with some details of the various cases and remarks on the powers of resistance in aged people.—Mr. BUTLER SMYTHE congratulated Dr. Remfry on the success of his case complicated with epithelioma, and asked if any mental symptoms had been observed previously to the operation. The patient had been under his care on two occasions, but had absolutely declined to have the tumour

removed. Her mind then seemed to be exceedingly weak, and her conduct and language extraordinary. She had been to several hospitals "to show herself to the doctors," but would not submit to any operative measures beyond aspiration of the cyst, which was twice performed. It was most gratifying to hear from Dr. Remfry that up to the present time there had been no recurrence of the epithelial growth.—Dr. LEWERS hoped that the after-history of the case as regards the vulvar epithelioma would be given to the society, as in his experience recurrence was much more likely to occur early than in cases of epithelioma of the cervix. Dr. Lewers mentioned a case under his care where, after apparently complete removal, recurrence took place in the inguinal glands five months after operation.—Dr. HEYWOOD SMITH said that in his case, referred to in the paper, the tumour was of enormous size (47 lb.), and prevented the patient from moving freely about. The adhesions to the abdominal wall were very strong, so that he had to leave a piece of the cyst wall the size of a dinner plate attached to the inside of the abdomen.—The PRESIDENT said that it must be remembered that people of eighty years and upwards were selected cases; they had outlived their contemporaries, and might be expected to be unusually sound. Dr. Remfry's paper illustrated the fact that cases which would not seem favourable often turned out well, and that a selection of ovarian cases on *a priori* grounds was unsatisfactory. The good results of operation for ovarian tumour with pregnancy illustrated the same fact.—Dr. REMFRY, in reply, said that the mental condition of the patient with epithelioma was perfectly satisfactory during her stay in hospital, except during convalescence, when she was irritable and difficult to manage for three or four days. There had been no recurrence of the epithelioma, which was excised in August, 1894. It was always necessary to verify a patient's age by obtaining if possible the birth certificate. He considered that after ovariotomy in old women nutrient enemata should be administered in order to prevent shock.

The following specimens were shown:—

Dr. CULLINGWORTH: (1) Embryo and Clot from a Tubal Abortion; (2) Diffuse Uterine Myoma.

Dr. DUNCAN: (1) Myoma undergoing Myxomatous Degeneration removed by Hysterectomy; (2) Œdematous Myoma removed by Hysterectomy; (3) Double Tubo-ovarian Cysts; (4) Dilated Tubes and Cystic Ovaries (early stage of tubo-ovarian cysts).

Dr. LEWERS: Tubal Gestation of Three Months operated on before Rupture.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Treatment of Empyema in Children.—Secondary Malignant Disease of the Lung or Pleura.

A MEETING of this society was held on April 5th, the President, Dr. BANNING, being in the chair.

Dr. COUTTS read a paper on the Treatment of Empyema in Children. He considered that there was a chance of cure by aspiration in cases with small cavities that are recognised in their early stages. If there were no improvement after two aspirations he thought that the method was inadvisable. Statistics were given of twenty-seven cases treated by simple incision, and of sixty-one cases treated by rib resection. Notwithstanding the unfavourable results of the former as compared with the latter, Dr. Coutts thought it should be tried in the more debilitated cases. After opening the chest he advocated washing out not only in cases with offensive discharge but in those of large dimensions with high temperature. He gave statistics of forty-three cases of empyema in children under the age of two years with twenty-seven deaths. Empyema is in itself so fatal at an early age that the responsibility for the high mortality does not rest on one operation or another. Although here again the statistics were favourable to the method of rib resection, Dr. Coutts was, on the whole, inclined to the opinion that simple incision was preferable in these infants.—Dr. MAY referred to the treatment of empyema after operation by immersing the patient in a warm bath.—Mr. BIDWELL mentioned that he had known caries of rib to follow resection for empyema in children, and therefore he was inclined to recommend simple incision in any case where the pus was not fetid; he thought, too, that the patient's stay in hospital was shorter after simple incision than after resection of rib. Washing out was only employed when the pus was offensive, and in children he had found a warm bath of bichloride of mercury (1 in 10,000) very satisfactory. He had treated two cases by washing out combined with immediate closure of the wound; in one case the result was satisfactory after a second operation, and in the other resection of rib was subsequently required.—Dr. COUTTS replied.

Mr. STEPHEN PAGET read notes of three cases of Secondary Malignant Disease of the Lung or Pleura. Case 1: Early stage of cancer of the pleura, secondary to cancer of the breast, with a note on the removal of the whole mammary gland without removal of the nipple. Case 2: Advanced cancer of the pleura with pleural effusion, secondary to cancer of the breast, with a note on the value of repeated aspiration in such cases, and on the sudden sleep that sometimes follows the sudden return of the lungs to their natural action. Case 3: Huge sarcoma of the lung secondary to subperiosteal sarcoma of the femur, with a note on the possibility of making a diagnosis in this case between a solid growth and an effusion; and on the influence, if any, of amputation at the hip-joint in preventing recurrence of the disease in these cases, the value of the inhalation of oxygen, and the use of Dr. Coley's erysipelas toxin. He said that the cases showed the value of a medical opinion in a surgical case, and of a surgical opinion in a medical case. They also raised important questions as to the diagnosis of these cases, and as to their treatment, both preventive and palliative.—Mr. MACADAM ECCLES pointed out the frequency with which recurrence occurred above the line of incision after amputation of the breast for cancer. With regard to the utility of amputation at the hip-joint for sarcoma of the thigh, he referred to two cases which were free from recurrence two and a half years after operation.—Mr. BIDWELL deprecated the practice of leaving the nipple when amputating the breast for cancer; he also advocated the complete removal of the pectoral muscle in all cases where the growth invaded the muscle.—Mr. PAGET replied.

NOTTINGHAM MEDICO-CHIRURGICAL SOCIETY.

Three Cases of Laryngeal Paralysis.—Graves' Disease.—Chronic Pharyngitis.

A MEETING of this society was held on March 20th, Dr. J. S. TEW, President, being in the chair.

Mr. GRAY read a paper for Mr. STEWART and himself on Three Cases of Laryngeal Paralysis. They divided laryngeal paralysis into: (1) neuropathic paralysis—(*a*) from central lesions, (*b*) from lesions of the superior laryngeal nerve, and (*c*) from lesions of the recurrent laryngeal nerve; and (2) myopathic paralysis. They illustrated this division by cases of paralysis of the superior and recurrent laryngeal nerves respectively and also a case of bilateral abductor palsy, which they claimed for the myopathic variety.—They also read a short communication on the Surgical Treatment of Graves' Disease, with some Considerations on its Pathology. They narrated two cases of Graves' disease for which isthmoidectomy had been performed, with very rapid improvement in the patients' symptoms. They discussed the alternative operation of removing half the gland with the isthmus, and claimed for isthmoidectomy equal efficacy and much less risk. Referring to the pathology of Graves' disease they passed in review the various theories laid down and arrived at the conclusion that the theory that answered all the facts best was the one which held that Graves' disease is a primary disease of the thyroid gland, and that the symptoms are due to a hyperplasia with exaggerated functions of the gland—in short, to hyperthyrea, just as those of myxœdema are now universally agreed to be due to the opposite condition of the thyroid, athyrea. They gave all the arguments for this view—especially the appearances seen microscopically in the gland (as summarised by Professor Greenfield in the Bradshawe Lecture of 1893)—the known symptoms of overdose of any of the thyroid preparations and the result of operations.

Mr. MACKIE read a paper on Chronic Pharyngitis and claimed that in the causation and maintenance of this condition the gouty and rheumatic diathesis was in the majority of cases the most prominent factor.—The President, Miss

Gray, Dr. Cattle, and Dr. Tresidder spoke, and Mr. Gray and Mr. Mackie replied.

Some Points connected with the Question of Operation in Acute Intestinal Obstruction.

A MEETING was held on April 5th, Dr. J. S. TEW, President, being in the chair.

An address was delivered by Mr. W. H. A. JACOBSON, of Guy's Hospital, on Some Points connected with the Question of Operation in Acute Intestinal Obstruction. He drew attention to the great mortality attending these operations and inquired why progress had not been so rapid as in many other branches of abdominal surgery. The small intestine was a peculiarly vital part, and in cases of obstruction there was not only local damage, but also far-reaching collapse on account of the important nerves at the root of the mesentery. It was futile to compare operations for the relief of internal obstruction with herniotomy; in the latter the operation was practically extra-peritoneal, while in the former the sac was the whole peritoneal cavity. A large proportion of cases were, and must necessarily remain, fatal, partly on account of the inherent vulnerability of the parts and the attendant collapse, and partly on account of the inability of surgical skill to detect or relieve the seat of strangulation. Cases of obstruction by bands, some internal hernise, some cases of gall-stones, and some intussusceptions were among those most favourable for operation; while the least hopeful, or almost hopeless, were cases in which complicated snaring and matting of the small intestine or severe volvulus were found. Another favourable class for operation was that in which acute obstruction supervened upon an unsuspected chronic obstruction. The unsatisfactory results of operation had led many practitioners to advocate a purely medical treatment. No doubt some cases so treated recovered, but they were probably cases of incarceration, not of strangulation. Enemata by the long tube were useless for severe acute obstruction. In discussing the question of operation he remarked that every case should be submitted to exploration if the patient's condition warranted it, and, provided the surgeon had a clear knowledge of how far it was safe to go, he preferred a tolerably free incision and described the method of rapidly searching for the obstructed point. No operation should be unduly prolonged; if the obstruction was not readily found it was better to open a distended coil, insert a Paul's tube, and close the abdomen.

Reviews and Notices of Books.

King's College Hospital Reports. Vol. I., Oct. 1st, 1893, to Sept. 30th, 1894. Edited by NESTOR TIRARD, M.D., F.R.C.P.; W. WATSON CHEYNE, F.R.C.S., F.R.S.; JOHN PHILLIPS, M.D., F.R.C.P.; and W. D. HALLIBURTON, M.D., F.R.C.P. London: Adlard and Son. 1895.

THE appearance of the names of four editors upon the title-page of this volume seems to have been necessitated by the complex nature of the task undertaken. From the subtitle we learn that the work comprises the Annual Report of King's College Hospital and the Medical Department of King's College, and, as the College includes numerous scientific laboratories, the labour of collecting material must have been considerable. That this should be the first volume of reports issued from this source may cause some surprise, which will not be diminished by the most cursory examination of the value of the various papers and reports. Professor Watson Cheyne, in a post-prandial speech, considers that King's men are "too modest and retiring." The clinical reports alone indicate that there may be some truth in this remark; but they afford evidence of abundant vitality and good material and render full justification for the appearance of another annual volume, in spite of the crowded condition of medical literature. The first paper is an instalment of a historical sketch of the college and hospital by Professor Curnow, which is especially interesting in tracing the origin of King's College, University College, and the University of London. Dr. Beale writes on the Curable Stage of some Incurable Maladies, chronic rheumatoid arthritis receiving the greater share of attention. Dr. Duffin contributes Clinical Considerations on the Abstraction of Blood. Dr. Tirard writes a short note upon a case of Functional Albuminuria met with in hospital work and illustrates the subject by a brief comparison of similar conditions which have come under his notice. Dr. Ernest White deals with the importance of Psychological Medicine in relation to the General Practitioner. A paper on Sneezing, read by Dr. Greville MacDonald before the King's College Medical Society, is conceived in a lighter vein, but is essentially practical. Dr. Silk is equally satisfactory in his exposition of the Principle of Selection as applied to the Administration of Anæsthetics. Mr. McHardy gives further experiences of the Artificial Maturation of Immature Senile Cataract by Trituration, but somewhat impairs the appearance of the book by marginal notes. Pelvic Suppuration in the Female supplies Dr. John Phillips with a subject for an instructive paper. Mr. Burghard gives his results in the Treatment of Gonorrhœa and Gleet by means of the Urethroscope. Mr. G. L. Cheatle has a short illustrated paper on Bursitis, and Dr. Aldren Turner gives an interesting account of the Value of the Discoveries of Sir Charles Bell. The medical and surgical reports have not been arranged upon the same system, but there may be much to be said in favour of each plan. Dr. Whitfield, the medical registrar, gives rather full notes of selected cases of interest. Mr. Cargill, the surgical registrar, has prepared a somewhat elaborate General Table of Surgical Cases, while Messrs. Rose, Watson Cheyne, Carless, and Beale deal more fully with the cases of interest that have been treated by them respectively. Dr. John Phillips supplies reports upon the Obstetrical Department and the Gynæcological Wards. Reports by Dr. Hayes and Messrs. McHardy, A. H. Cheatle, and Underwood deal with special departments and are somewhat brief. Dr. Dalton gives a careful classification of the work in the Pathological Department. The reports from the various Practical Departments and Laboratories, in the table of contents attributed to Dr. Halliburton, appear to have been written by different hands; at any rate, other initials are attached to the Historical Sketch of the Anatomical Department, a sketch which will please a former generation of students by its kindly picture of Partridge. A somewhat novel feature is supplied by the pages which record What Old King's Men are Doing—a list likely to be studied with interest by old King's men. The volume reflects great credit upon all concerned in its production, especially when the initial difficulties of such an undertaking are considered. In the preface the editors appeal for "sympathetic indulgence" in starting a new venture. Careful consideration of the work in this volume leads to the conclusion that sympathy should be extended rather to those who in future will have to maintain the same high standard.

A Handbook of Hygiene. By Surgeon-Major A. M. DAVIES. London: Charles Griffin and Co. 1895.

DURING the last few years a very large number of works on hygiene and public health have been issued from the press, and the cry is "Still they come." We are glad, however, to welcome Surgeon-Major Davies's book, for we feel that he has had ample opportunity during the years in which he was assistant-professor in the school of hygiene which Parkes founded to make himself one of the masters of the science, and he has therefore a right to speak. The author claims but little originality; his aim has been to make himself acquainted with what has been written by approved authorities, to compare and weigh different statements, and to digest the information into as small a compass as seemed advisable, while omitting nothing of real importance. The book, which is about the same size as Willoughby's "Health Officer's Pocket-book," contains some 580 pages and will doubtless be very useful to medical men and to officers of the

Army Medical Staff serving abroad, where, as often happens, only books of a minimum size can be carried. Taking the old saying that "a man can live three weeks without food, three days without water, and three minutes without air" as his guide, Surgeon-Major Davies has considered the three chief needs of man in the order of their relative importance. There are also chapters on the Removal and Disposal of Sewage, on Clothing, on Habitations, on Personal Hygiene, on Soils and Sites, on Climate and Meteorology, on the Causation and Prevention of Disease, and on Disinfection. The appendix contains a useful comparison of metrical and English weights and measures, and notes on solutions for chemical analysis, on cultivation media, and on some of the elementary points in statistics. Though all the subjects treated of are necessarily condensed, the book is well and clearly written, and is pleasant to read. The author has succeeded in bringing the work wonderfully well up to date—not an easy matter in these days of rapid progress. It is sufficiently illustrated and we feel we can recommend it. The book is appropriately dedicated to the memory of Dr. F. de Chaumont.

LIBRARY TABLE.

Text-book of Anatomy and Physiology for Nurses. By DIANA CLIFFORD KIMBER, Graduate of Bellevue Training School, Assistant Superintendent, New York Training School. New York and London: Macmillan and Co. 1894.—This work is written in a clear and easy style, and is fully illustrated with excellent engravings. The various chapters follow the order usually adopted in anatomical treatises, commencing with the bones and passing on to the joints, muscles, sanguineo-vascular system, lymphatics, respiratory organs, alimentary canal, urinary organs, skin, nervous system, organs of special sense, and finally the female generative organs. With the description of these several parts is incorporated an ample and very satisfactory account of their mechanical and physiological functions. The book consists of 260 large octavo pages, and probably contains more anatomical and physiological information than is likely to be required by the class of readers for whom it is designed. A considerable amount of histological detail is introduced, and some paragraphs on embryology as well. The authoress expressly defends this in her preface, but many persons will nevertheless adhere to the opinion that the majority of nurses will profit but little by instruction on the subject of the peritoneal endothelium (p. 91), or multipolar nerve cells (p. 200), or the embryonic development of bloodvessels and corpuscles (p. 117). Amid the profusion of highly-finished engravings the reader will perhaps feel the absence of a simple diagram showing the surface areas corresponding to the contents of the chest and abdomen—an extension, in fact, of that shown on p. 154. The volume is handsome in appearance and leaves nothing to be desired in point of mechanical execution; but its treatment of the subject is far too copious and extensive for the purposes of the average nurse, and the next edition will be greatly benefited by free retrenchment of anatomical details.

Posological Table. By WILLIAM CRAIG, M.D. &c., Edin. Edinburgh: E. and S. Livingstone.—This is a useful little book, containing a tabular arrangement of all the Pharmacopœial preparations, with their doses and methods of administrations. A table on Poisons and an Index of Diseases with Appropriate Remedies are included. In our opinion tables of the latter class are of very little use, especially when under the head of Diseases we find symptoms such as "dropsy" and "jaundice" tabulated.

The Last Abbot of Glastonbury and his Companions. By FRANCIS AIDAN GASQUET, D.D., of the Order of St. Benedict. London: Simpkin, Marshall, Hamilton, Kent, and Co., Ltd. 1895.—These biographical sketches carry the reader back to monastic life in England during the reign of Henry VIII. The commanding position of Glastonbury Abbey among the English religious houses naturally entitles its Abbot to the chief place in the volume, the other subjects of pourtrayal being Hugh Cook, last Abbot of Reading, and Thomas Marshall, or Beche, last Abbot of Colchester. The author considers that the origin of Glastonbury Abbey was of a date previous to the Christianising of the Anglo-Saxon settlers in England. He does not occupy himself with its history until the year 1525, when Cardinal Wolsey appointed Richard Whiting, a monk belonging to the community, to be the abbot. Great political and ecclesiastical upheavals were at that time imminent. In less than ten years Henry defied the authority of the Pope, and required the clergy of the kingdom to swear allegiance to himself as head of the Church. Abbot Whiting and his community, fifty-one in number, accordingly made the required declaration in 1534. Henry, however, resolved to include in his anti-papal measures the destruction of the monastic system, and his agents found that the law of royal supremacy provided an easy means of attack. Abbot Whiting, having been interrogated at the Abbey by special Royal Commissioners, was sent to the Tower in 1539 on a charge of treason, and in November of that year was executed at Glastonbury and his body quartered. Such lamentable cruelties seem to have been inseparable from religious strife in that intolerant age; the wholesale suppression of the monasteries was, moreover, a ruthless act unworthy of a powerful monarch and a great misfortune to the cause of art and learning. The volume is profusely illustrated, chiefly with charming photo-engravings of monastic architecture.

MAGAZINES AND REVIEWS FOR APRIL.

The Phonographic Quarterly Review.—The success which has attended the efforts of a few medical men to form a Society of Phonographers and the interest which several prominent members of the profession have taken in the movement would lead us to suppose that phonography is destined to become a useful adjunct to medical teaching. To those proficient in the art, and even to those who have but a tyro's acquaintance with it—for the outlines are clearly and beautifully lithographed—the appreciative sketch in the quarterly before us of Dr. Jameson, C.B., written by his old teacher Dr. Gowers, will be perused with feelings of pride. It is by his own choice, Dr. Gowers tells us, that the man who is entrusted with the charge of a kingdom remains simple Dr. Jameson, the title by which he is so well known. As the circumstances under which Dr. Jameson first went to South Africa are but little known, and as an erroneous account has been given in a recently published book, we translate that portion of the article which gives the facts as told to the writer by Dr. Jameson himself. While resident medical officer at University College in 1878 one of the staff went into his room and asked him if he knew a man who would go out to South Africa to take up a partnership there. It was three months before the expiration of Dr. Jameson's two years' term of officership. For a moment he was silent, and thought, "I have no definite prospect here; it is hard to make way; this is sure." He replied, "I will take it, sir." "But you have to go at once," said the questioner. "I will take it, sir," repeated Dr. Jameson. Two days later the future administrator of the British Chartered Company's territories left England. This is so characteristic of the quiet determination of the man that it is worth recording, and has no doubt had a great deal to do with his success. "The Political Status of the Uitlander," by a Uitlander, will be found a fresh contribution to the proper understanding of an old problem, relating to the same part of the empire with which Dr. Jameson is so intimately connected. Another article well worth reading is a short account of the elements of the

hieroglyphic system used by the ancient Egyptians. It will be remembered that Dr. Thomas Young, a member of our own profession, shared with the great French orientalist, Jean François Champollion, the honour of discovering the meaning of the hieroglyphics on the Rosetta Stone and thus threw a flood of light on the meaning of ancient Egyptian writing. Dr. Norman contributes an article on the Evolution of the Post Office Savings Banks.

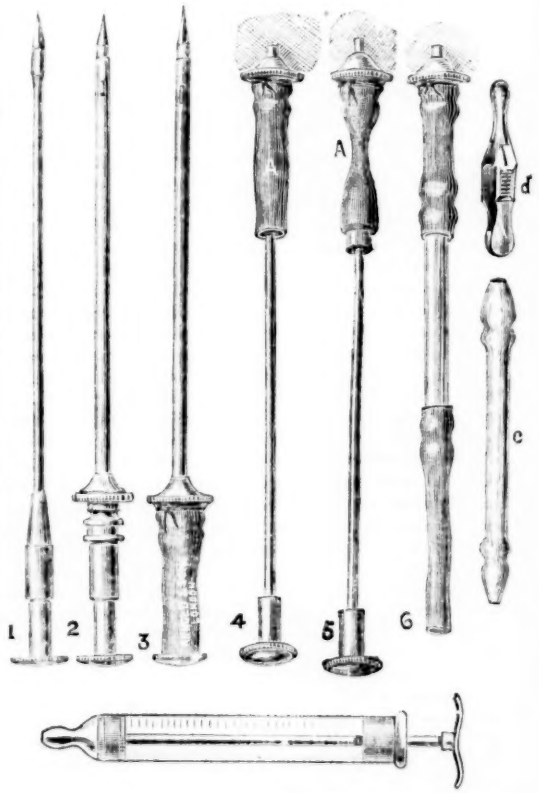
The English Illustrated Magazine.—The April number of this magazine has a very good list of names—George Gissing, Stanley Weyman, and Archdeacon Farrar amongst others. There is an article upon Sandwich Men, which is a pathetic account of a much-to-be-pitied class. Miss Violet Hunt, deserting her usual dialogue form, has a short story called an "Encore," which is to be commended for the absence of inaccuracy in the account of the heroine's illness. The typical illnesses of fiction writers are, as a rule, of a kind unknown to pathologists, and we are always thankful when we come across a writer who successfully avoids these pitfalls.

New Inventions.

A NEW INSTRUMENT FOR EXPLORING AND DRAINING CAVITIES.

THE instrument which I am about to describe, of which a short notice appeared in THE LANCET of March 30th in the report of the Clinical Society, has been used many times in the wards of St. Bartholomew's Hospital, and in the hope that it may prove generally useful I venture to bring it before the profession in your columns. It is intended for exploring, draining, or aspirating any cavity, is simple, free from taps and screws, portable, readily cleaned, and can be boiled in a test tube. The instrument consists of a cannula and trocar made in three sizes. The cannula differs from Potain's in having the mount smooth inside, so that the air-tight chamber on the trocar fits directly into it without intervening tap (Fig. 2). The trocar (Fig. 1) has a thick neck half an inch long; its air-tight chamber is a solid metal cylinder, smooth outside, and without any concealed washer or packing within; the trocar can be drawn back through it until the point is buried, but no further. Before use, a piece of rubber tubing one inch and a half long is fitted on to the mount of the cannula, and secured by a thread tied round in the groove provided. When the trocar is put inside, the rubber covers the air-tight cylinder and also the neck of the trocar; it is now ready for use (Fig. 3). The instrument is thrust into the cavity and the trocar drawn back into its cylinder (Fig. 4); in doing this it is well to hold the cylinder at A, lest it be drawn out of the cannula with a jerk. The cylinder is then given a slight twist to ensure that it is loose, and is withdrawn through the rubber tube by steady traction on the trocar; when the rubber is wet and traction is exerted steadily it comes out quite smoothly. While withdrawing the cylinder, the rubber is pinched with finger and thumb, or clamped with bulldog forceps to prevent ingress of air (Figs. 5 and D).

The cannula is thus left in the cavity ready fitted with drainage-tube. If, now, exploration is intended, a glass syringe is inserted into this tube; if drainage or aspiration is required the tube is pinched again and the syringe replaced by a glass tube (Fig. C) previously connected either with a long drainage-tube full of water (Fig. 6) or with a Potain's bottle. Failing the bottle, a Higginson syringe will replace it for aspiration, especially if the valves of the latter are cut off and the fingers used instead. Each cannula has a blunt rod as well as a trocar to match. To clean the inside of a cannula after use, draw a few threads of soft white darning cotton through it by means of a loop of silver wire provided. Two pairs of bulldog forceps go with each set of trocars, the set being sent out in a neat metal box, which can easily be carried in the pocket. One pair of forceps is used to clamp the drain-tube, and keep it full of water until fixed. My syringe, for exploring with my cannula, is a ten c.c. glass syringe, the glass having no metal attached to it, so that it is readily cleaned. The plunger is of asbestos, it can be compressed by an adjustable metal disc, so as to insure always an accurate fit in the barrel. The screw cap in general use in such syringes is replaced by a rubber cork lined and capped with metal, it is more convenient than a screw cap, and is, I am told, much easier to make. The handle of the piston is very comfortable to hold. Every part of the syringe takes to pieces, and can be boiled. Attached to a hypodermic needle, such as is sent out with the trocars, by a stout rubber tube, this syringe does excellently for injecting antitoxin, and has been used for the purpose in the diphtheria ward at St. Bartholomew's Hospital. A pair of test tubes is sent out with the syringe, in which trocars, cannulæ, rubber tubes, and hypodermic needle can be boiled; they have rubber caps with a slit in the top, which allow the tube to be boiled nearly full, without the water bumping out, the steam escaping through the slit. Before boiling make the slit



gape by pulling down the cap, and after, close it by pushing up the cap, and the tube will remain sterile until required. The syringe and test tubes are sent out in a box together, with or without four feet of drainage-tube; in hospitals the latter need not be carried, being always obtainable. With a box of trocars in one pocket, and the above in another, the practitioner is ready for the exploring and draining of nearly any pleuritic or ascitic effusion. For the rare cases where the syphon action of the drain-tube full of water is insufficient, and it is nevertheless necessary to withdraw the fluid without incision, he must carry or borrow a Higginson syringe. The Potain's bottle is, of course, better if at hand. The practitioner is also equipped for the injection of antitoxin, and he carries his sterilising apparatus with him. In tapping the abdomen I find it best to lay a small pillow across the patient's knees to support the instrument and keep its end well down inside. The trocars and cannulæ are made by Messrs. Arnold and Son of West Smithfield, and the syringe and test tubes by Messrs. Baird and Tatlock of Cross-street, Hatton-garden.—GEORGE C. GARRATT, M.B.,

Late House Physician, St. Bartholomew's Hospital, and Hospital for Diseases of the Chest, City-road.

Little Tew, Enstone, Oxon.

THE LANCET.

LONDON: SATURDAY, APRIL 13, 1895.

THE *raison d'être* of a medical society being the interchange of opinions upon pathological, clinical, and therapeutical facts, it is clear that the members should be of one mind as to the essentials of medicine and pathology. The introduction amongst them of persons who, having gained the necessary qualifications to practise, enter upon their profession by repudiating the bases of its science, and adopt a name which affirms this openly, is both undesirable and unseemly. It was, therefore, with some surprise that we learnt a short time since that at least one of our metropolitan societies comprised some so-called "homœopaths" amongst its members. Now it seemed to us that—because as in the matter of consultation upon an individual case so also in a conference upon any question of scientific interest there can be no common ground between the homœopath and the general body of the profession—it would be important to learn whether any means were generally adopted which would ensure that such societies should be free from members of this class. Accordingly we addressed a letter to the hon. secretaries of thirty-six medical societies (eighteen London and eighteen of the leading provincial ones), asking for information, firstly, as to whether any members of the medical profession who were avowedly homœopaths were members of the society; and, secondly, whether there was any rule or regulation with reference to the admission or exclusion of homœopaths. We received replies from sixteen of the London and fifteen of the provincial societies, for which we tender our thanks to the gentlemen who sent them.

There is a striking uniformity in the information thus furnished to us. With only two exceptions the first question is answered in the negative, the majority in the direct manner, the rest more cautiously stating that they (i.e., the hon. secretaries) "are not aware" of any such members. It is within the bounds of possibility that a comparison between the various rolls of members and the names contained in the publication known as the "Homœopathic Directory" would reveal some striking concordances even in the most select of the societies. But if this be so the members in question have been careful in their action in the society, just as they are sometimes careful in their communications to medical journals, to keep their peculiar tenets in the background. There are, however, two societies, both, singularly enough, devoted to the same special line of study, where the presence of one or more homœopathic members is acknowledged. From the one society we learn that "this society has at least one member who is avowedly a homœopath"; from the other that there are three such members, two of whom joined at the formation of the society, whilst the third was elected subsequently, "and did not then practise homœopathy." In the case of this latter society two out of the three homœopathic members had offered papers for reading, but the council, after discussion, declined to have them read—a practical illustration of the inconvenience attending the inclusion of homœopathic practitioners in the ranks of a medical society.

As regards the second question, one only of the London societies and three of the provincial have rules against the admission of homœopaths as members. In the majority of the societies reliance is evidently placed upon the fact that nomination from personal knowledge is required, and on the power of the ballot-box. Whether these safeguards are sufficient may well be questioned when consideration is given to the wholesale manner in which ballots are taken at the leading societies. There would be less chance of a practitioner of this kind in a provincial town gaining admission to a society than there is in London; but obviously the important thing is to enforce circumspection on the part of those who nominate. The metropolitan society referred to has always had the excluding regulation in its by-laws, and it is now proposed to make this by-law read as follows: "Subscribing members must be duly registered medical men, but no one shall be a member or eligible for election as such who is practising as a homœopath, or engaged in carrying on, or assisting in carrying on, any form of irregular practice, or who is resorting to any methods for procuring patients or practice which is derogatory to the practice of medicine, surgery, or obstetrics as a profession. And the council shall have power at any time to remove from the roll of the society the name of any member who shall be proved to have transgressed or to be transgressing this law."

This is explicit and is not unworthy of imitation by older and larger bodies. It is all very well for a society or its council to express or give an opinion as to the "unadvisability" of admitting homœopaths, and to open the doors to all registered medical practitioners, as most of these societies do; but then they have only themselves to blame if perchance it be shown that papers have been accepted and read by avowed homœopaths, or other "irregular practitioners," and discredit accrue therefrom to the society.

Nor is it on the ground of tenets alone that the "homœopath" should be excluded from a properly regulated medical society. The fact is that the practice of homœopathy in the strict sense is as infinitesimal as its dosage. What the profession generally have to complain of, what they justly resent, and the ground upon which they are right to decline coöperation is that in practising, as he is bound to do in every department except the limited one of drug treatment, the homœopath follows the canons of medical and surgical practice as universally laid down. He calls himself a "homœopath," and maybe he joins the staff of a "homœopathic hospital," but for all that is done in that hospital—or, for the matter of that, out of it, too—the cognomen has no real meaning, except in so far as it deludes a public only too ready to be impressed by every fanciful medical theory.

OUR contemporary, *Blackwood's Magazine*, in its last issue deals with the old but still ever fresh and insistent question, the habitual criminal, and how civilised society should deal with him. If inquiry and discussion sufficed to solve a difficult problem, and remove one of the greatest sores in the body politic, we might fairly expect to be soon rid of the habitual offender, for few questions are more frequently or more earnestly discussed; but there is reason to fear that

the progress achieved has not been at all commensurate with the efforts put forth. Our contemporary lays down three preliminary dicta—viz., first, that the present method of dealing with our habitual offenders, vagrants, beggars, and inebriates is almost, if not entirely, void of deterrent effects; secondly, that some treatment other than that carried out by our prison system is necessary; and thirdly, that reform is urgently required in our liquor laws. "Hitherto," says the reviewer, "Government inquiries and social science discussions have been conducted as if the principal point to be ascertained was how the existing habitual offenders could be improved. The greater part of the labours of the Departmental Committee now sitting seems so far to have been expended in that direction. We venture to submit that these labours would be much more profitably bestowed if they were devoted to the purpose of stopping the source of supply rather than of dealing with the ready-made offender." This is, no doubt, sound and true. The habit of crime, like the habit of intemperance, is almost, though happily not altogether, ineradicable. As in disease, so in crime, preventive treatment is much easier and more fruitful than curative treatment. We think, however, that it cannot be justly alleged against our legislators that they have been indifferent to measures intended to strike at the root of the genesis and propagation of crime. The industrial school and reformatory system, popular education, and sanitary reform have always had as either their direct or indirect object the removal of conditions that favour the development of the habitual criminal. The subject in its purely legal or political aspects is somewhat outside our province, but the writer in *Blackwood* sees clearly that it is also a question of health, hygiene, and *morale*, and to these phases of the problem we may profitably direct the attention of our readers. A great political leader once said that one of the fundamental duties of the statesman was to endeavour to make well-doing easy and ill-doing difficult. This is profoundly true, and medicine has much to say on the subject to which the statesman would do well to listen. *Ex nihilo nihil.* The habitual criminal is not a *lusus naturæ*, but a necessary, though deplorable, product of false and unsound conditions of domestic, social, and political life.

The reviewer says truly that one of the great causes of our social evils is that the mass of the lower classes are so deplorably deficient in the knowledge of "how to live." He urges that the children in our schools should be taught some of the frugal and thrifty habits of the poor in France and Germany, that "the rudiments of thrift and order, of thorough cleanliness and regularity in daily life, of gentleness and politeness, of kindness and consideration towards one another, should be instilled into them as the very essence of their existence." Further—and here he touches on matters regarding which the medical profession can have much to say—he urges the importance of improving the housing of the poor, of providing more light and air, open spaces, recreation grounds, and the like. This is all most true and wise, but we are happy to think that the public conscience is by no means asleep on this aspect of the question, and that immense progress has been and is being made. Our artisan population is certainly much the best housed of any European nation, and we do not think that in any country of Europe the general principles of hygiene and sanitation have permeated the popular mind so widely as they have done in the United Kingdom. It is hardly necessary now to stop to prove that every effort put forth to render life among the lower classes brighter and more wholesome is an indirect blow at the development of intemperance and crime. This is universally admitted by everyone competent to give an opinion on the subject, and our chief present need is to stir up public authorities everywhere to enforce principles the correctness of which is indisputable. The great danger of municipal and other such bodies is that they may fail to have the courage of their convictions, and that they may allow considerations of economy or self-interest to over-ride the public welfare. One of the saddest reflections that can occur to us is the thought of how far practice in these matters falls short of admitted principles. We tamper with Nature's laws because obedience to them is very costly or very inconvenient, and sooner or later Nature takes a terrible revenge upon us.

A minor but still important phase of the evolution of crime is the difficulties which the poor encounter in obtaining wholesome and properly cooked food. There can be no doubt that bad food, intemperance, and crime represent a very common link of causation. As regards the quality of the food-stuffs offered for sale in our markets, we are probably ahead of most nations, but in knowledge of cookery and in skill in turning every food material to the best account we lag most deplorably behind. Education might do much in this particular, but it must be education directed to this specific end. Cookery-classes are now becoming general and deserve every encouragement, but, unhappily, the poor have too often neither the time nor the means to profit by them. We need the general establishment of working men's kitchens, such as those which have been founded so successfully in Vienna, where the poorer classes could obtain an appetising and wholesome meal at a minimum of cost, and we trust the day is near when such institutions will be general in this country. Facilities for popular recreation are another important item in the process of cutting at the sources of crime, and here, too, we think there is considerable progress. It is exceedingly important that popular amusements should be conducted under wholesome hygienic conditions and be kept as free as possible from morbid excitement of any kind.

While we thus lay stress on the material and physical causes that affect the production of crime, we by no means argue that these exhaust the subject. There is, of course, a moral and psychical side of the question. On this, however, we do not propose on the present occasion to enter.

AN event which created considerable interest in medical Scotland on March 28th was the business that took place at the General Council of the University of St. Andrews. There probably never was an occasion on which so large a General Council was known in this University, and there certainly was never one in which so many graduates of medicine were present at one and the same time. Graduates arrived from all parts of the country, and the station-master at Leuchars is reported to have said that he never before had had "such a number of doctors passing through his hands." The reason of so much interest had relation to the establishment of

two new medical chairs in the University, a chair of Materia Medica and a chair of Anatomy. For some time past an attempt has been made to blend the University of St. Andrews with the University College of Dundee, in order to establish a complete school of medicine, with various degrees as in the other Scotch Universities. The difficulty of making a complete union rested practically in the division of powers and of chairs, the two amalgamating bodies being largely incompatible for union. St. Andrews, as is well known, is one of the oldest and most classical of the Universities, an ancient seat of learning, quiet, retired, and by ages dignified—a school, in short, having a remarkable and ancient history. The University College of Dundee, on the other hand, is quite a modern school, well equipped, ready for work, full of youthful vigour, but in the opinion of some determined to win more than a mere partnership when united to the older body. It seemed, we understand, to St. Andrews men as if the old University were going to be transferred to Dundee, that the living University would be in Dundee, and that the ruins of St. Andrews would remain as an archæological appendage over the water. Degrees might still be conferred with the after-ceremonial of capping within the time-honoured walls, and some antiquated chairs might still be the seats of some of the professors; but the life was to be in Dundee, and everything was to date henceforth from that active commercial centre. Most of the graduates in medicine felt it a pity to make such a vital change, but it was almost *un fait accompli*. The situation has, however, recently entered a new phase.

The late Mr. DAVID BERRY, of Coolangatta, near Sydney, a Fifeshire gentleman, left the ancient University some time ago a legacy of £100,000. There was a tendency indicated by his trustees for the University Court of St. Andrews to turn this munificent bequest to the purposes of medicine and science in the University itself. We cannot say with certainty that this was the sole cause of a rupture between St. Andrews and Dundee, but it had its bearing and has had its full share in the dispute that has been going on, and which has come now to so distinct a difference that it has been proposed to dissolve the union between the two institutions altogether, or at least to make such an alteration that they shall re-start on a different basis from that which had previously been expected. In January last, therefore, it was proposed in the University Court of St. Andrews that two chairs should be founded in the University and endowed out of the Berry bequest, to be called respectively the Berry chair of Materia Medica and the Berry chair of Anatomy, with a view to giving two *anni medici* at St. Andrews. The University Court, by a small majority, passed its resolution to this effect; but as the decision was considered even by some of the members of the University Court itself to require wider confirmation, and as it was opposed by many of the Senate, the matter came before the University General Council at the meeting held on March 28th to which we have called attention, when the following resolution, moved by Professor PETTIGREW and seconded by Sir BENJAMIN W. RICHARDSON, was carried by 74 votes to 38: "That the General Council heartily approved of the action of the University Court in founding from the Berry Bequest two additional chairs at St. Andrews as calculated to improve the general usefulness of the University, and resolved that every available means be taken by the Council to secure their success as well as that of the extended medical school at St. Andrews as a whole." Two amendments for negativing this resolution were put to the meeting, but both were lost, and the effect of the resolution, it is believed, will be that competent professors will be elected, and that St. Andrews will be enabled to prepare medical students during their first two years of study. There will be then, with chairs already existing, chairs of Anatomy, Physiology, Chemistry, Natural History, Materia Medica, Physics, Botany, and Mathematics, all of them doing good work for students who are preparing to undergo the more practical teaching of the profession in the wards of a hospital. The seconder of the resolution advocated the new plan energetically. He maintained that these preliminary studies would take the place of the old apprenticeship system in medicine, which had its unquestionable advantages, and he urged that anatomy itself could be taught with far greater benefit elsewhere than within a hospital. Students, he contended, would be following an unhealthy study under the healthiest conditions that could be obtained, and sick people would avoid the risk of being exposed to the danger arising from the student leaving the dissecting-room to go at once round the sick ward. There was, of course, some opposition to this argument, but the majority of the voters seemed to be in favour of the change.

The decision, given on Monday last in the House of Lords, in regard to the powers of the Scottish University Commission will, of course, have to be taken into account. For the moment it seems to be decidedly in favour of St. Andrews University maintaining its present attitude.

Annotations.

"Ne quid nimis."

THE PRESIDENCY OF THE ROYAL COLLEGE OF PHYSICIANS OF LONDON.

IT must be gratifying to Sir J. Russell Reynolds to find that his services as President of the Royal College of Physicians of London have been recognised by the Fellows, who by 76 votes out of 80 have elected him for another term of office. This practically unanimous vote will be endorsed by the profession in general, who acknowledge in the President one who has worthily merited the honours bestowed on him by his Sovereign and his College. In accordance with custom, before retiring from his year of office Sir Russell Reynolds delivered an address, reviewing the work of the College during the past year, and sketching in clear and appropriate language the main facts in the careers and the individual characteristics of those Fellows who have died during this period. It was, he admitted, an innovation to include in this list the most distinguished on the roll of Members, Dr. Greenhill, but the new departure was fully justified, not only by the fact that long since Dr. Greenhill had been selected for the Fellowship, which he had declined, but also by his singular pre-eminence as a scholar and his fine and honourable character. The pupil of Arnold, and contemporary at Oxford with A. P. Stanley and Newman, his classical attainments led him more in the path of literature than of science, and enabled him to unlock

the treasures of ancient medical writers for the benefit of his countrymen. The singularly varied career of Dr. Brown-Séquard was sketched in bold outline, and the opinion expressed by Sir J. Russell Reynolds that the fame of the successor to Claude Bernard would rest on the work done in his earlier days rather than that of his later life is doubtless true. The unobtrusive career of Dr. Little, who although a physician became through his personal affliction the leading authority on a department of orthopædics; and the single-minded, just, and honest character of Octavius Sturges, whose election as Senior Censor (within a few weeks of his untimely death) had been universally approved as a fitting testimony to his worth; the genial Withers Moore, and the venerable Bisset Hawkins, whose name had long appeared as the oldest Fellow on the College roll; and, lastly, the industrious and painstaking career of Daniel Hack Tuke, who has left behind him many a *litera scripta* as well as affectionate regard to keep his memory green—gave material for the records of men who had worthily maintained the honour of the College of which they were distinguished ornaments. They were depicted in faithful terms by the President, than whom none could have better fulfilled the duty; and the vote of thanks accorded to him, on the motion of Sir Richard Quain, was certainly well earned.

THE PRESIDENCY OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

IN e'ecting Mr. Christopher Heath to the presidential chair the Council of the Royal College of Surgeons of England have taken a course which was very generally expected of them, which was amply justified by the public, private, and scientific character of their nominee, and which will give genuine pleasure to all sections of the profession. Mr. Heath is known to the whole of the surgical world as a fine exponent of his art, and as a wise, practical, and liberal-minded man, and we are certain that in his capable hands the office will shirk none of the responsibilities that are its inseparable burden, that its dignity will be fully maintained and its utility amply proven.

"ILLEGAL VACCINATION."

IT is, unfortunately, notorious that there is a large amount of irregular and inefficient vaccination in this country, and there is every reason to believe that it is increasing. An illustration of this appears in the report of the last meeting of the Lincoln board of guardians, which had under consideration a communication from the Local Government Board containing extracts from a memorandum by Dr. Bruce Low appended to his report as inspector of public vaccination in the union. The extracts were as follows:—

"During the course of my inspection of public vaccination in the Lincoln Union it came to my notice that the wife of a qualified medical man, Christopher Montgomery Davidson, M.R.C.S., L.S.A., was in the habit of vaccinating a large number of cases at her husband's surgery. The certificates for such children were signed 'C. Davidson.' While visiting cases vaccinated by the Lincoln public vaccinator in the poorer parts of Lincoln, I and my colleague, Dr. Reece, who accompanied me, came upon children who had been vaccinated by Mrs. Davidson. Careful questioning of the mothers elicited the fact, in each of the cases we inquired into, that the children had been vaccinated and inspected by Mrs. Davidson, who took from the mother the certificate, saying she would send it to the vaccination officer. In none of the cases where we interviewed the mothers had Mr. Davidson been present at the vaccination or inspection, nor had this gentleman at any time seen the child's arm during the course of its vaccination. Vaccination officer says that Mrs. Davidson's name is Eliza, and that the character of her handwriting is of a very similar character to her husband's, in fact he cannot distinguish between them. In 1892 some 332 cases, and in 1893 395 cases were certified by 'C. Davidson.' Many of the cases done by Mrs. Davidson are stated to have only one scar. This lady vaccinates weekly, and I am told the number done by her grows, the mothers being attracted by the fact that only one mark is made when desired."

Mr. Davidson is not one of the public vaccinators, but it was decided to transmit to him a copy of the report and ask for an explanation. It is provided in the Act that a vaccination performed and certified by an unqualified medical practitioner will not protect the parents of children who obtain such certificates from being liable to prosecution. On the other hand, we opine that the General Medical Council would take notice of a qualified practitioner signing certificates of cases he has not seen. The incident further illustrates the laxity with which the term "successful" is used in application to vaccination. That "one mark," no matter how obtained, can be returned as a successful vaccination proves that the vaccination laws, however well framed as regards the public service, have no control over others, who do not hesitate to practise vaccination inefficiently at the request of persons whose sole desire is to evade the intention of the law whilst obeying its letter. The small-pox statistics of the past decade would have presented a different aspect than they do had vaccination been carried out by all practitioners with the efficiency demanded by the Local Government Board of its public vaccinators. The country will surely expect from the Royal Commission a definite pronouncement on such anomalies as are illustrated by this Lincoln case.

WHAT IS "PREMATURE DISCHARGE" FROM A FEVER HOSPITAL?

ALTHOUGH we are asking this question it may be at once confessed that we see no immediate prospect of being able to answer it; but we raise the issue as affording opportunity for some remarks upon the subject. From time to time we have narrated and discussed in our columns instances in which cases of infectious disease, notably scarlet fever, have occurred in houses shortly after the return to them of patients from fever hospitals; and the question has arisen as to whether these fresh outbreaks were due to careless discharge on the part of the hospital officials or to other causes. We are tempted once more to touch upon this extremely interesting and to medical superintendents of fever hospitals very important subject, since we notice that in recent reports to the Islington sanitary authority the medical officer of health makes reference to cases of scarlet fever which have arisen shortly after the return to certain houses of children discharged from one of the metropolitan fever hospitals. The first case to which we will refer was that of a boy who on admission to hospital was, according to the medical superintendent, suffering from eczema and not, as certified, scarlet fever. It appears, however, that the child developed scarlet fever four days after admission, and that eight weeks from the time of attack was examined for discharge. At this time the child is stated to have recovered from scarlet fever, but to have been still afflicted with an eczematous condition of the hands and feet. Sixty-two days after the onset of scarlet fever the child was discharged, and some four days later the child's sister developed scarlet fever. The medical attendant considered the discharged child had not completely desquamated, and the medical officer of health, on his attention being called to it, reported concerning the child, "His hands are desquamating profusely, while his feet are so to a much less extent." The child was returned to hospital, and the medical officer of health considered it had been prematurely discharged. The next case regarded as prematurely discharged was admitted to hospital on Sept. 22nd and sent out on Nov. 23rd. On Nov. 28th a brother with whom the child slept on the night of its discharge developed scarlet fever, as shortly afterwards did two other children. The medical officer of

health inspected the discharged child on Dec. 6th, and found on its head "three large and thick patches of dandriff, while over the eyebrows there was slight but very perceptible desquamation." With regard to the first case, there appears to have been a difference of opinion as to the meaning of certain conditions seen on the hands and feet. Profuse desquamation on the hands, nine weeks after the onset of scarlet fever, is certainly, in our experience, somewhat unusual. The second case was retained in hospital approximately nine weeks, and on being examined two weeks after discharge was said to be desquamating on the eyebrows. In both instances scarlet fever broke out in the houses shortly after the return of the patients from hospital, and it is, we think, a legitimate inference that these fresh attacks were due, directly or indirectly, to the returned cases. The question, however, would seem to be whether the appearances observed on the second child's eyebrows and head eleven weeks after attack were such as to justify the conclusion of premature discharge; or whether such conditions may not, quite apart from scarlet fever, be frequently found on children's faces and heads. Again, is there not such a thing as recurrent desquamation, and may not a patient discharged with a clear skin subsequently in a fresh environment evince a partial redesquamation? There is, perhaps, at the present time a tendency to regard the fact of scarlet fever developing in a house shortly after the return to it of a discharged hospital patient as evidence of carelessness on the part of the hospital officials; but it is against conclusions of this kind that we would here enter a protest. Before such a decision can be legitimately arrived at it is surely necessary that the details of disinfection practised at the patient's home should be thoroughly gone into, and this even in face of the fact that a discharged patient evinces signs of separating cuticle. We published in THE LANCET of April 6th a paper read by Dr. Joseph Priestley before the Epidemiological Society. In that paper he states that, although during the small-pox epidemic in Leicester he sent to their homes 120 children in every stage of desquamation after scarlet fever, not a single second case occurred. That there is sometimes carelessness in the discharge of patients we are far from denying, but at the same time we are not prepared to admit that the disinfection of houses is always carried out in a manner calculated to effect its object. These "return" cases will, experience seems to teach us, sometimes occur in spite of the utmost care, and the fault, if such it be, may at times lie at the door of the fever hospital, and at others at that of the sanitary authority. When, however, regard be had to the fact that a child discharged from a fever hospital has been for weeks inhaling a more or less highly infected atmosphere, is it not contrary to expectation, as it certainly is to experience, to suppose that any process of disinfection at present known to us, short of destruction of the patient's life, can be absolute; and would it not therefore tend to diminish the chances of "return" cases if parents were advised, where possible, to avoid placing a child fresh from a fever hospital in the same bed with a susceptible brother or sister?

THE CHITRAL EXPEDITION.

THE expedition to Chitral has begun well as far as our military success and the impression which this is calculated to have on the hill tribes, with their strong fatalistic superstitions, are concerned. But the Government of India cannot have gone into this campaign in the present state of Indian finances with a light heart, for it is evident that it will cost many lives and much money before it is over. Our quarrel is exclusively with Umra Khan, and we have to force our way through to Chitral; but there is every reason why we should try to secure, if possible, the friendship, and not the enmity, of the mountain tribes through whose territory we must pass to get there. The political situation seems to be a complicated one, and it is most unfortunate that it has been forced upon the Indian Government by the unjustifiable action of Umra Khan. The topographical difficulties to be overcome are very great in a mountainous warfare of this nature; passes have to be scaled and taken and rivers to be crossed; and setting aside the fighting and the laborious nature of the marches, the transport of food, baggage, ammunition, and the provision of an adequate amount of water *en route* are no easy matters. The force was compelled by the political and military necessities of the case to start at once, and it is always difficult to obtain the requisite amount of animal transport on such occasions, as everybody knows who has ever taken part in such expeditions. As regards the fighting qualities of the force there can be no doubt, and there need be no misgiving in this respect. So far they have done extremely well, and there is every reason to hope that Surgeon-Major Robertson and the British garrison at Chitral are safe and can hold out until successfully relieved. Meanwhile it is satisfactory to learn that according to intelligence received at the India Office the wounded are doing well.

LAMP ACCIDENTS.

ON Friday, the 5th inst., no less than seven lives were lost owing to the upsetting or explosion of lamps. At Canning Town the mother of a family upset an oil lamp, an explosion is said to have followed, and the shop where the accident happened was at once in a blaze. The flames spread very rapidly, and five children who were asleep in one of the rooms were suffocated. The other accident was due to the explosion of a spirit lamp, two children being burned to death. The many instances which have occurred of deaths from the upsetting or explosion of lamps do not yet seem to have taught the users of lamps the obvious lesson. There are plenty of safety lamps now in the market at prices to suit all pockets, and we believe the London County Council is doing good work in the detection and destruction of lamps which are little less dangerous than a dynamite shell; but much still remains to be done with regard to the education of those who use lamps, and are compelled by stress of circumstances to buy them cheap.

THE TREATMENT OF FROST-BITE.

THE occurrence of frost-bite is more common in some parts of America than it is in England, but nevertheless it occurs sufficiently often to render a paper on its treatment one of interest to all medical men. Dr. Hermance of Philadelphia publishes his experience in the *Philadelphia Polyclinic* of March 9th. He divides the dermatitis of frost-bite into two classes, firstly, cases in which the injury is so severe that vesicles or blebs are formed; and, secondly, milder cases which go on to recovery without the formation of vesicles. Of thirty patients selected at random for consideration five applied for treatment immediately upon finding that the parts were becoming numb. The five patients were subjected, firstly, to prolonged rubbing with snow, followed by douches of ice-water, and afterwards applications of ichthyol ointment (25 per cent.). The remaining twenty-five patients did not apply for relief until the parts had begun to exhibit pain and increase of heat. Of these twenty-five, eighteen were treated with ichthyol ointment (33·3 per cent.), four with benzoated collodion, and three with a solution of nitrate of silver (10 per cent.). Twelve of the whole number of thirty cases were seen twenty-four hours after the first dressing. All had been treated with the ichthyol ointment, and all reported relief from pain experienced to a great extent immediately upon application, and lasting in most cases for more than twelve hours. Eight of these cases exhibited blebs upon the affected parts; the vesicles were punctured, the serum

drained, and a second dressing of ichthyol ointment applied. The remaining four of the first group were so completely relieved that they were discharged without further treatment. Of the remaining eighteen cases returning in from forty-eight to ninety hours after first treatment, two of the three patients who had been treated with nitrate of silver were discharged cured; two of four treated with benzoated collodion reported increase of pain, and blebs had formed; while in the other two treatment had failed to modify the course of the affection. Eleven cases thus remain unaccounted for; these were all treated with ichthyol ointment at the primary dressing, and eight were discharged after having received a second dressing of ichthyol. Of the total thirty, nine were of a serious character, in which there were lesions of the entire skin, and in some cases of the superficial fascia; these cases were treated with ichthyol ointment until the parts became raw and exposed when acetanilid ointment (10 per cent.) was applied. In a certain number of cases (five) the destruction of cutis was so great, and the disturbance of the vaso-motor mechanism so serious, that treatment failed, and nothing could be done except to wait until nature threw off the injured tissues and to assist in the meantime by keeping the parts aseptic.

IS TERRESTRIAL HELIUM A NEW DISCOVERY?

IN our issue of two weeks ago we announced the discovery, by Professor Ramsay, of another new gas, which, in company with argon, he obtained from the mineral clèveite, by merely acting upon it with sulphuric acid. This new constituent proved to give the spectroscopic characters of an element hitherto supposed to exist in the sun, to which therefore the name helium was given. Professor Ramsay has obtained a considerable quantity of this mixture, we learn, and hopes soon to be able to report upon its properties; and since helium has been regarded as much lighter even than hydrogen the determination of its actual density promises to be of unusual interest. If helium could be obtained in tolerable quantity, what an important bearing it might have in aeronautics. Thus, if it be much lighter than hydrogen its lifting power would be much greater, and the cumbersome and clumsy dimensions of our present balloon, it is easy to see, could be reduced with very great advantage. Was this wish father to the thought, we wonder, when, more than fifty years ago, Edgar Allan Poe, in his narrative of the adventures of Hans Pfaall, referred to the use of a gas much lighter than hydrogen for inflating the balloon in which he undertook his thrilling journey. The passage referring to the preparations for the balloon voyage is so remarkable in connexion with recent chemical discoveries that we reproduce it in its entirety. Thus, after referring to the purchase of numerous instruments and materials for experiments in the upper regions of the upper atmosphere, Hans goes on to write:—

"I then took opportunities of conveying by night, to a retired situation east of Rotterdam, five ironbound casks, to contain about fifty gallons each, and one of a larger size; six tin tubes, three inches in diameter, properly shaped, and ten feet in length: a quantity of a *particular metallic substance, or semi-metal*, which I shall not name, and a dozen demijohns of *a very common acid*. The gas to be formed from these latter materials is a gas never yet generated by any other person than myself—or at least never applied to any similar purpose. I can only venture to say here that it is a *constituent of azote*, so long considered irreducible, and that its density is about 37·4 times *less than that of hydrogen*. It is tasteless, but not odourless; burns, when pure, with a greenish flame; and is instantaneously fatal to animal life. Its full secret I would make no difficulty in disclosing but that it of right belongs (as I have before hinted) to a citizen of Nantz, in France, by whom it was conditionally communicated to myself. The same individual submitted to me, without being at all aware of my intentions, a method of constructing balloons from the membrane of a certain animal, through which substance any escape of gas was nearly an impossibility. I found it, however, altogether too expensive, and was not sure, upon the whole, whether cambric muslin with a coating of gum caoutchouc was not equally as good. I mention this circumstance because I think it probable that hereafter the individual in question may attempt a balloon ascension with the novel gas and material I have spoken of, and I do not wish to deprive him of the honour of a very singular invention."

The italics, *which are not ours*, might well have been at the present juncture. Could it possibly have been the conception purely of a highly imaginative and poetic mind, or had Edgar Allan Poe really learned from a friendly philosopher of the existence of a gas lighter than hydrogen, and whose discoveries may not have reached us for a host of conceivable causes? Perhaps Professor Ramsay or Lord Rayleigh will explain.

INFLUENZA PRECAUTIONS IN MANCHESTER.

JUDGED by the weekly returns of the medical officer of health for the week ending March 23rd—the last which has reached us—the mortality occasioned by influenza appears to be still in the ascendant, the deaths in the week referred to having numbered 33, as against 23 for the previous week. Having regard to the persistence of the malady, Dr. James Niven has, we notice, recently issued a placard setting forth briefly the precautions it is expedient that those attacked and exposed to infection should take. After indicating the symptoms of the disease and referring to its infectivity, Dr. Niven advises workpeople to wear warm clothing and to avoid unnecessary exposure during the prevalence of the disease; and he also points to the importance of paying special attention to the cleanliness and ventilation of factories and workshops, with the view, we presume, of diminishing the risks of infection and promoting recovery. Dr. Niven has done well to issue this notice, and it will do good if only it induces those attacked not to return to work too soon. Unfortunately, we fear many of the workers of Manchester can only partially follow the advice of their medical officer of health; but we trust, for the sake of themselves and those dependent upon them, they will do what they can. If the financial loss to the community of Manchester which the after-effects of influenza have already entailed could be worked out and expressed in figures, it would be a strong inducement to a proper appreciation of Dr. Niven's placard.

THE ROYAL MEDICAL BENEVOLENT COLLEGE.

THE appeal issued by the authorities of the Royal Medical Benevolent College in connexion with the approaching festival should come with force to all successful or moderately successful members of the profession. The chair will be taken by the Right Honourable Arthur J. Balfour, M.P. When a statesman of the first rank and with innumerable engagements accepts such a duty, the least that members of the profession whose benefit is contemplated can do is to support him by their presence or their substantial sympathy. A larger subscription is urgently needed to keep up the present annual outlay in charity of £6000. There is a sound of good news for the pensioners of the College. The scheme for improving their condition has received important help from the will of the late Dr. Bowen. The Council hope to be able to raise the annuities of all non-resident pensioners, and that the recipients will be enabled to spend their declining years with their friends. This can only be done, however, in perpetuity by the generous support of the subscribers. The school is open to all classes. The Foundation scholars—fifty in number—receive an education of the highest class and are boarded, clothed, and maintained at the expense of the College. They are elected by the governors from the necessitous orphans o

such medical men as would be eligible for pensionership. Besides these there are about 185 resident pupils. If the sons of medical men, they are charged £60 a year for education, board, &c.; if not, they are charged £70 a year. The introduction of the sons of other than medical men is not only a source of gain and profit to the College, enabling it to do more helpful and benevolent work for the necessitous members of the profession, but it is a distinct advantage to introduce scholars with other callings in view than the medical, and representing other classes. Variety is most desirable. There is the same variety and all-roundness in the teaching. Though science teaching is principally considered, with three laboratories and a lecture theatre, there is a good classical school, where the education is mainly classical, but with a due addition of mathematics, French, German, Latin, natural science, history, geography, and last, though not least, English. The school is recognised by the Conjoint Board as a "school of science," and pupils are prepared for the matriculation examination of the University of London. Special arrangements are made for army candidates, and two boys have recently been prepared for Sandhurst. The ten medical scholarships at the hospital schools in London, ranging from 90 to 125 guineas, and other scholarships or exhibitions at the universities, tend greatly to facilitate the career of any meritorious boy. It will be an inducement to all who are benevolently disposed to give liberally at the approaching festival to know that their donations or subscriptions will go only to the general fund for pensioners or Foundation scholars. We learn that H.R.H. the Prince of Wales has consented to lay the foundation stone of the new buildings contemplated by the council in June.

THE ANTIQUITY OF MAN.

IN the current number of the *Nineteenth Century* Professor Prestwich adduces some new facts in support of the great antiquity of man on this planet. The history of opinion on this subject is curious. So recently as 1847 the Geological Society declined to publish a paper which aimed at showing that man co-existed with the extinct quaternary mammalia. Then came the researches of M. Boucher de Perthes, near Abbeville, which proved the existence of human weapons in the quaternary beds containing the fossils of the mammoth, woolly rhinoceros, hyæna, reindeer, &c. Then Professor Prestwich, Sir John Evans, and others showed that undoubted worked flints were present in shingle containing mammalian remains, and so men of science became satisfied that palæolithic man existed in post-glacial times. Here the question rested for a time, but in the course of time inquiry was naturally directed to the problem whether the relics met with in the valley drifts were the work of the earliest race of men. "The workmanship on some specimens of the palæolithic implements was not very much inferior to that of neolithic times, and what was known of the human frame indicated but slight, if any, inferiority in its physical structure to that of modern man. All led one to suppose that ruder ancestors preceded palæolithic man." The most important recent discoveries have been on the North Downs in Kent. Here implements of various kinds—scrapers, drills, hand-picks, roughly chipped flints, &c.—have been found, and Professor Prestwich is disposed to assign a very high antiquity to them. These implements appear to have been used for hammering, for breaking bones, for scraping skins, bones, and sticks, and for chipping and trimming other stones for use. He believes that their age must be assigned to some time previously to, or contemporaneously with, some part of the glacial period. According to Professor Prestwich the appearance of palæolithic man—that is to say, the man of the valley drifts—does not extend probably beyond a distance of about 20,000 to 30,000 years, and his disappearance at about from 10,000 to 12,000 years, from our own time. Other authorities, such as Croll, have assigned a much more remote period; but while absolute agreement on a matter so difficult is not to be expected, it is evident that geologists are more and more becoming of opinion that a very high antiquity of man is practically certain.

THE MIDWIFE QUESTION.

AN inquest was held on the 3rd ult. at Gainsborough on the body of a woman who had died in childbed, being attended by a midwife until late in the labour, when a medical man was sent for. The patient died from, according to the verdict, "internal rupture." The coroner made the very admirable remark that "midwives were very good when a doctor could not be got, that though in Gainsborough they had every medical facility, still a certain class would persist in employing a midwife, and that the deceased had lost her life simply from not having proper medical attendance."

"GLASS, WITH CARE."

IT is noteworthy that serious inconvenience and even injury may result from the most trifling imprudence. A few days ago a barman accidentally fell, broke a bottle he had in his pocket, and received a wound in the leg from the broken glass which caused him to be laid up in hospital. His was a very simple, though an expensive, act of carelessness. Most persons must plead guilty to having repeatedly offended in like manner, and the lesson clearly taught by this accident to all such need not be impressed by further demonstration. For obvious reasons an injury by broken glass is especially troublesome, and it constantly gives rise to subsequent suffering due to retention of broken fragments in the wound. A little forethought in carrying or in handling and opening bottles will usually prevent such awkward consequences of incaution as that above related. Its exercise is the more advisable since bottle glass, even when new, is not guaranteed as free from cracks or other defects.

A NEW ILLUMINANT.

MOST persons have at times noticed a not offensive but peculiarly pungent odour given off from gas stoves in which from insufficient air-supply the combustion is more or less imperfect. This is acetylene, C_2H_2, a poisonous gas especially fatal to vegetable life. It has hitherto been the practice to estimate the higher hydrocarbons of coal gas in terms of olefiant gas or ethylene, C_2H_4; but Professor Vivian Lewes has shown that in the flame they are all resolved into acetylene, and that, having the highest possible percentage of carbon, it is the most powerful of illuminants. Till recently its preparation in the pure state has been difficult and costly, but since it has been found that calcic carbide when slaked evolved this gas, in accordance with the equation $CaC_2 + H_2O = CaO + C_2H_2$, at the rate of over five cubic feet per pound, and that by heating together chalk and carbon of any kind in the electric furnace the carbide is produced at a cost of about £4 per ton, it is proposed to employ acetylene for enriching poor gas either at the works or in the house of the consumer or to burn it in specially constructed lamps. If its poisonous character be understood its strong penetrating odour will be a sufficient safeguard. In this respect it contrasts favourably with carbon monoxide, CO, the most poisonous constituent of coal gas, and a product of incomplete combustion which is quite inodorous. The cost of acetylene would probably be about 7*s.* per 1000 cubic ft., but its illuminating power is 240 candles, or fifteen times greater than the gas at present supplied to London. Still the tendency to deposition in the

form of soot of the excess of carbon which may possibly escape combustion is an almost insuperable objection to all processes for employing these very high hydrocarbons, and it would perhaps be better to seek "more light" in the direction first pointed out by Drummond in the limelight, and followed by Dr. Auer von Welsbach in his incandescent gas burner, only seeking a less fragile material for the "mantle" than the present form, which is composed of certain rare earths.

PAIN FOLLOWING EXTRACTION OF TEETH.

AT a recent meeting of the Odontological Society of Great Britain a very interesting case of pain following the extraction of a tooth was brought to the notice of the members by Mr. Storer Bennett. The patient, who was a female aged twenty-three, had suffered pain, periostitic in character, from an upper third molar. The tooth was removed without difficulty, but the socket remained intensely painful for the next twelve days, in spite of the repeated applications of such remedies as strong carbolic acid, tincture of aconite, cocaine, and hot poppy fomentations. During this period the socket granulated healthily, except at its apex, where on examination a spot about the size of a pin's head was discovered, which appeared white in colour, and caused on being touched the greatest agony. Thinking that the case was due to the exposure of the end of nerve Mr. Bennett treated it by "division of the nerve just below the surface of the wound." The result was completely satisfactory, the pain ceasing immediately after the operation.

THE NATIONAL LEPROSY FUND.

A SUBCOMMITTEE, consisting of Sir Joseph Fayrer, Sir W. Guyer Hunter, and Mr. Hutchinson, was appointed by the National Leprosy Fund in January, 1894, to conduct such further investigations as to the nature and causes of leprosy as might seem desirable, and it may be remembered that this subcommittee announced in our advertisement columns that they were prepared to offer honoraria of fifty guineas each for the best reports on the following subjects:—(1) On the facts as to the recent increase of leprosy at the Cape and its present prevalence in South Africa; (2) on the history of the decline and final extinction of leprosy as an endemic disease in the British Isles; (3) on the extent to which leprosy prevails in Persia and neighbouring countries, and its supposed causes; (4) on the prevalence of leprosy in the islands of the Pacific, and the supposed exemption of certain groups; (5) on the conditions under which leprosy at present prevails in China, Cochin China, Batavia, and the Malay Peninsula; (6) on the conditions under which leprosy has declined in Iceland, and the extent of its former and present prevalence; (7) on the history of leprosy in Madagascar, and the conditions of its present prevalence; (8) on the reputed recent increase of leprosy on the Australian continent, its extent and possible causes; (9) are there any islands in the East Indian seas wholly free from leprosy, and, if so, in what do their conditions differ from those in which it prevails? (10) the best essay on any subject connected with leprosy (the honorarium for this essay was, if the committee thought fit, to be added to any of the preceding). We have received from the subcommittee and adjudicators of the awards the names of the gentlemen who have gained prizes in the different subjects, and they are as follows:—On the Facts as to the Recent Increase of Leprosy at the Cape and its Present Prevalence in South Africa: S. P. Impey, M.D., Medical Superintendent, Robbin Island. On the History of the Decline and Final Extinction of Leprosy as an Endemic Disease in the British Islands: George Newman, M.D. On the Conditions under which Leprosy has declined in Iceland and on the Extent of its Former and Present Prevalence: Edward Ehlers, M.D., of Copenhagen. On the Reputed Recent Increase of Leprosy on the Australian Continent; its Extent and Possible Causes: Ashburton Thompson, M.D. On the Conditions under which Leprosy prevails in China, Cochin China, Batavia, and the Malay Peninsula: James Cantlie, M.B., of Hong-Kong. On some of the subjects for which prizes were offered no essays have been received. Some of those which were sent were not considered by the subcommittee to be sufficiently full to meet the terms of the competition. We are asked to announce that unsuccessful authors can have their manuscripts returned on application at 1, Park-crescent, Regent's-park.

THE METROPOLITAN HOSPITAL SUNDAY FUND.

THE trustees of the will of the late Mr. William A. Gaesdon have informed the Lord Mayor of London that in pursuance of the powers vested in them by the will they have chosen certain charitable institutions to participate in the estate generally. Under the scheme it is understood that a sum of £45,346 1*s.* 3*d.* in Consols is to be transferred into the names of the Official Trustees of Charitable Funds, who will remit the dividends on the Consols to the Lord Mayor of London for the time being, in trust for the Hospital Sunday Fund. We congratulate the Council of the Fund on this handsome augmentation of their income, and trust that it may be a long time before the trustees in whom the discretion is vested will find a charity more worthy of their assistance. The interest on a further sum of £9069 4*s.* 3*d.* has been left to the Mansion House Poor-box.

THE CONFERENCE ON SANITARY PROGRESS AND REFORM AT MANCHESTER.

THE annual meeting of the Manchester and Salford Sanitary Association on April 24th will inaugurate a conference to extend over three days. It is promoted by the association in connexion with the district councils for the registration of plumbers in the northern and midland counties. The former will occupy the Wednesday and Thursday, and the latter part of Thursday and Friday. The subjects to be chiefly dealt with in the first part of the Conference are Air Pollution, Sanitation of Schools, Recreation—both Physical and Mental, and Woman's Work in Sanitary Reform. Addresses and papers are promised by Sir R. Rawlinson, Sir B. W. Richardson, Cardinal Vaughan, Lord Meath, Mr. Charles Roberts, and others. An International Health Exhibition is to be held in St. James's Hall, which will open on April 22nd and close on May 11th. It is under distinguished patronage and will be on an extensive scale.

THE MODERN TRAINED NURSE.

SIR DYCE DUCKWORTH has always taken a deep interest in nursing and in the Royal British Nurses Association, of which he is vice-president, and in an address delivered before this body the other day he laid stress upon various important points connected with the profession of nursing, and not the least of these was the absolute necessity, as he pointed out, of a nurse being subservient to the medical man. The old style of nurse has so entirely disappeared that the patients and practitioners of this generation can hardly realise how much the successful treatment of disease owes to the help of an intelligent, trained woman; and this expression, *trained*, means, as Sir Dyce Duckworth clearly pointed out, not only medical and physical knowledge, but tact and silence. The abbot of a Nitrian monastery once gave one of his monks as a rule of life the first verse of the psalm commencing, "I said I will take heed to my ways, that I offend not with my tongue." "When you can keep that rule," he said, "come, and I will give you another." Tradition has it

that the worthy monk never arrived at the second. Be this true or not, it shows how the tongue in all ages has been regarded as an unruly member, and all nurses ought to remember to be absolutely silent as regards anything they may see or hear outside their own immediate duties. The Hippocratic oath still remains the canon for every attendant on the sick, either nurse or medical practitioner, and on this point Sir Dyce Duckworth rightly spoke with great earnestness.

LORD ROSEBERY'S HEALTH.

WE had hoped to be able to announce that the Premier was now entirely restored to his usual health. Unfortunately, however, his recovery is not yet quite complete, although he is making good progress. It is chiefly owing to want of sufficient sleep that his convalescence is retarded. Lord Rosebery is able to take riding and walking exercise daily—a fact of good import, as there can be no better remedy for insomnia than healthily acquired fatigue.

THE ISOLATION HOSPITAL ACT IN WORCESTERSHIRE.

THE Worcestershire county council, to which Mr. George Fosbroke is medical officer of health, has exhibited considerable activity in the matter of joint hospital districts, and two such districts have recently been formed. In both instances one or more of the constituent authorities petitioned the county council, under the provisions of the above Act, that certain joint hospital districts should be constituted, and in each case an inquiry was subsequently made under Section 6 of the Act by the county medical officer of health. The council considered a *primâ-facie* case made out and, after local inquiry as provided for by the Act had been held, the Bromsgrove, Droitwich, and Redditch, and the Malvern hospital districts were established. A hospital committee has in each case been provided for by the order, and such committees are possessed of extensive powers as regards management &c. They have, however, no power to raise money by loan for the purposes of a hospital. Such powers would appear to be alone possessed by the county council, who, with the consent of the Local Government Board, are, by the Local Government Act, 1888, empowered to borrow for the purpose indicated. It seems, too, that under the Isolation Hospitals Act, 1893, any money so borrowed must be repaid to the county council by the local authorities with interest at the rate of 4 per cent. We shall look forward to the further development of affairs in connexion with these two districts, and we note with pleasure that in the Malvern district provision is already made for a separate small-pox hospital. The committee in each instance is composed of representatives from the local areas concerned, and the county council have no representation upon them.

UNHEALTHY AREAS IN LEEDS.

LIKE most large cities, Leeds suffers to-day from the ignorance or indifference of our forefathers in "the good old times" as to the conditions necessary for healthy town life, in being compelled to spend large sums of the ratepayers' money in order to remedy ancient blunders. The sanitary committee has just obtained the sanction of the Council for the preparation of a scheme for dealing with one notoriously unhealthy district of seventy-seven acres. This is a large undertaking, and the medical officer of health, Dr. Cameron, is to be congratulated on his courage in attacking sanitary evils so boldly, and in being so loyally supported by his committee and by the Council. The district has long been known as "a standing menace to the health of the city." Forty years ago typhus fever constantly prevailed, but the people objected to interference by the sanitary authority, so that "the aid of a posse of police had to be sought when typhus fever patients were removed to hospital." And its old reputation has been well kept up, for the death-rate is 30 per cent. more than the average of the city, including this area, notwithstanding many attempts to improve its sanitary condition. It is proposed to open out the district by running through it certain main roads, which will be a great public convenience; to alter certain levels and steep gradients; to pull down and demolish bad property, but to leave standing large works and public buildings. The cost is roughly estimated to be between £300,000 and £400,000. The sale of the cleared land is expected to bring in a good round sum. The scheme proposed divides the area into five sections, to be dealt with separately and not all at once. In the discussion on the question one gentleman said, "What about the Leylands? There was not a dirtier place in Leeds; people slept in the cellars there and yet did not die." This weighty argument did not prove effective, for in the end the resolution of the sanitary committee was carried by 47 to 5. On the question of rents one speaker said: "The Corporation had the power to build back-to-back houses, which could be erected and let at a minimum rent." If this power is acted on it will be a notable instance of retrograde progression which Leeds will surely not take.

THE ETIOLOGY OF LOCOMOTOR ATAXY.

DR. PITRES of Bordeaux has made extensive investigations in the hope of throwing light upon the still doubtful points in the etiology of this disease. His first results were published in a thesis by Dr. Bereni and comprised 225 cases. The influence of syphilis was found to be great but not overwhelming, and was by no means in keeping with recent ideas on the subject. In considering those cases in which the etiology was certain there were 125 out of 225—i.e., 55·5 per cent.—and even in many of these cases the syphilis was associated with other causes of tabes dorsalis as hereditary joint affections, alcoholism, sexual excess, &c., so that the exact percentage which could safely be attributed to syphilis was reduced to 22·33 per cent. Of the other patients about 33·44 per cent. had no sign of previous syphilis, and twice during his experience Dr. Pitres has seen tabetic symptoms precede syphilitic manifestations, so that these statistics tend to show that though syphilis is a cause it is not by any means the only one, but that many other conditions also play their part in setting up the disease. There is also in Dr. Bereni's work a chapter on the investigation of the heredity of tabes, but no direct tendency to inheritance was found.

TRAINED NURSES AT A WORKHOUSE.

SINCE the issue of the circular from the Local Government Board at the beginning of the year upon workhouse administration, in which special stress was laid upon the absolute necessity of supplying good nurses, numerous boards of guardians, at any rate in Sussex, at once gave the matter their attention. A board in South-west Sussex appointed a head nurse and two assistants, but the time they did duty at the workhouse was so short as to be able to be counted by the hours. At the first meeting of the board after the arrival of the nurses the master stated: "They defy the authority of the master and the matron, and find fault with everything, in short." An important point, it appeared, was that the nurses refused to bath the vagrants. In that the nurses were workhouse nurses, the guardians considered that this was part of their duty, but the head nurse held quite a different opinion, and one in which the medical officer concurred. So short a time had the nurses been in the workhouse that their appointment had not been confirmed, and by mutual consent they

remained but a very hours in the service of the guardians after their meeting. It was admitted by more than one member of the board that the nurses had been the means of discovering many imperfections which otherwise, perhaps, for some time to come would have continued to remain dormant—one beneficial result of the Local Government Board's circular. It is needless to add that the whole matter is to receive the full consideration of the guardians, and we hope means will speedily be adopted whereby such a state of things which has existed in the workhouse in question will entirely disappear.

THE Radcliffe Travelling Fellowship at Oxford has been gained by Mr. Arthur C. Latham, M.A., M.B., Ch.B., of Balliol College. Mr. Latham graduated as a First Class in the Final Natural Science Schools in Physiology in 1892 and a Second Class in the Final Natural Science School in Chemistry in 1890. He obtained a University Scholarship at St. George's Hospital, London, 1893, open to students of Oxford or Cambridge. Mr. Latham is a son of Dr. P. W. Latham, the late Downing Professor of Medicine in the University of Cambridge and the present Senior Censor of the Royal College of Physicians of London.

MR. H. J. WARING, M.S., M.B., B.Sc., F.R.C.S., of St. Bartholomew's Hospital, has been awarded the Jacksonian Prize of the Royal College of Surgeons of England. The exact title of his Jacksonian Essay is "The Diagnosis and Surgical Treatment of the Diseases of the Liver, Gall-bladder, and Biliary Ducts." Mr. Waring holds the appointments of Senior Demonstrator of Anatomy, and Demonstrator of Operative Surgery, at St. Bartholomew's Hospital; and Assistant Surgeon to the Metropolitan Hospital.

IN another column will be found a report of the first day's proceedings of the German Congress of Internal Medicine, which has been taking place this week at Munich under the presidency of Professor von Ziemssen. The discussion upon the Antitoxin Treatment of Diphtheria was one of great importance and had been anticipated with interest.

SIR JOSEPH LISTER was received by the Prince of Wales at Marlborough House on April 9th, and was presented by His Royal Highness with the Albert medal of the Society of Arts, which had been awarded to him in recognition of his application of antiseptic methods to practical surgery.

THE Festival Dinner of the Royal Medical Benevolent College will be held at the Queen's Hall, Langham-place, on Wednesday, May 15th. The Right Honourable Arthur J. Balfour, M.P., will take the chair.

THE REPORT OF THE SANITARY COMMISSIONER WITH THE GOVERNMENT OF INDIA FOR 1893.

(*Concluded from p. 868.*)

WITH regard to the prevalence of enteric fever—that scourge of our European troops serving in India—the returns for 1893 show that there has been a slight decrease in admissions and deaths. The improvement, we are told, is hardly appreciable, however, in Bengal and Madras, but more marked in the Bombay Presidency. At Sialkot, Agra, Meerut, Lucknow, Bareilly, Umballa, Rawal Pindi, and some other stations the disease was specially prevalent, the admission-rate ranging from 49·3 at Sialkot to 21·7 per 1000 at Bareilly. At Agra, where the admission-rate was 42·6 and the death-rate 12·43, there was a circumscribed outbreak in the East Surrey Regiment, in which no less than 42 occurred out of a total of 48 cases in the garrison. Mr. Hankin, the chemical examiner and bacteriologist for the North-West Provinces, found, it will be remembered, typhoid bacilli in the aerated water and in the *dahi* (eaten in the shape of cream, cheese, or sweetmeat) supplied to the regiment. As regards the greater liability of the young soldier recently arrived in India to be attacked with this fever there can be no doubt. It is a matter which has been already threshed out, and the evidence in the present is but a repetition of that in former reports. A comparison of the relative liability of European troops, native troops, and gaol population to enteric fever shows its very unequal incidence upon Europeans and natives in India.

	Per 1000.			
	1882–1891.		1893.	
	Admissions.	Deaths.	Admissions.	Deaths.
European troops	14·7	4·13	20·0	5·29
Native troops	0·3	0·09	0·3	0·04
Gaol population	0·2	0·10	0·3	0·16

From some of the descriptions recorded of the post-mortem appearances in natives it is not clear that they were all really cases of enteric fever. The Goorkha regiments seem, on the whole, to be more liable than other native troops to this disease—a fact which possesses some interest. Our knowledge of the etiology, causes, and pathology of enteric fever in India cannot be said to have been greatly advanced of late. Assuming that the disease depends upon the Eberth-Gaffky bacillus, the question narrows itself into an investigation into the life-history of that bacillus and the way in which it finds an entrance into the human body. It seems clear that ordinary domestic filters are incapable of removing pathogenetic microbes from water. The barrack filters at present in use in India apparently afford little or no protection to the troops; indeed, it is questionable, as we have said, whether they are not sources of danger. We repeat that every care should be taken to secure a good and pure water-supply at its source and to keep it free from all contamination. The Pasteur-Chamberland or Berkefeld filters should, we think, replace the filters ordinarily used in India. It might be very advisable, too, if some economical and easy method of destroying typhoid excreta by fire could be adopted. Some observers entertain the view that all the cases of enteric fever encountered in India, although clinically and pathologically allied to that fever in other countries, are either not necessarily identical with it in causation or, assuming that they are all of the same nature and attributable to one and the same specific cause, that the generation and reproduction of this cause do not take place exclusively in the human body. Be all this as it may, however, it is clearly our duty to search out and remove those causes which have been already established. Although the part which sewer air, for example, may play in its production may be still open to doubt, and in the case of India there are no sewers except in some of the cities and large towns, the evidence that has been adduced in regard to contaminated water and milk as causes of this fever does not seem to admit of any doubt. The difficulty in regard to some outbreaks in India is to explain on this theory the relative or absolute immunity of children and women on such occasions.

The amount of inefficiency in the European army in India attributable to venereal diseases is, we may almost say, appalling, especially when we consider the impaired health and subsequent constitutional effects of syphilitic infection. During 1893 there were, we are told, 2619 men, or the strength of nearly three regiments, constantly in hospital for venereal diseases.

The report under review has, as usual, an interesting table showing the results of a tour of Indian service upon European corps. Out of 872 men in one regiment who came to India sixteen years before only 8 returned with it: 66 had died, 114 had been invalided, 8 returned to England, and the remainder had been transferred to other regiments or discharged from the service.

The proportion of married to unmarried soldiers in India is 2364 of the former to 69,422 of the latter; in other words, the percentage of married to total strength is 3·29. The statistics regarding the women show a great improvement in 1893 in respect of admission and death-rates upon those of 1892, which were unusually high. The chief causes of death among soldiers' wives were enteric fever, puerperal fever, childbirth, and remittent fever. In the Bengal Presidency the death-rate was 16·26 per 1000, in Madras 7·66, and in Bombay 15·85.

The children of the army in India, amounting to a strength of 5662, had an admission-rate of 554·9 and a death-rate of 39·03 per 1000 respectively in 1893. There were no deaths recorded from cholera, and only 4 from enteric fever, the ages of the children ranging from infancy to fifteen years and upwards.

There were 6382 officers on the strength of the army in India on July 1st, 1893. The death-rate of officers of the British service was 10·67 per 1000, and of the Indian service 8·62; the difference is due to the larger number of deaths from enteric fever among the former, the respective numbers being 11 and 1, and the explanation of the difference, we are informed, and no doubt correctly, is probably due to the fact that officers do not join the Indian service until they have served for a year or two with a British regiment in India.

As regards the native army of India its average strength was 127,091. The year 1893 is stated to have been one of the most healthy in its history. The cholera mortality was the lowest on record. The admission-rate was 862, the deaths from cholera were 0·20, from all causes 10·29, and including absent deaths 12·81 per 1000 respectively. The chief causes of death were pneumonia and other respiratory diseases, remittent and intermittent fevers. Pneumonia caused 33 per cent. of the total mortality, and other respiratory diseases 13 per cent. It is pointed out in the report that a comparison of the diseases of the native troops and those of Europeans shows how much less the former suffered from enteric fever, heat-stroke, and venereal diseases, while, on the other hand, the Europeans suffered less from influenza, pneumonia and other respiratory diseases, dysentery, and scurvy. While the admission ratio for venereal diseases in the European army in 1893 was 466 per 1000, it was only 36·4 per 1000 among native troops. Many causes may be assigned for this great difference; for instance, the restraining influence of caste, the temperate habits, smaller pay, and frugality of the native soldier.

We pass over that section of the report dealing with the gaols of India and come to that of the vital statistics of the general population. As regards the principal diseases which contributed to the mortality of 1893, we find that cholera was less prevalent than in 1892 with the single exception of Assam; small-pox was also less prevalent; the fever mortality in Berar, Lower Burma, and Mysore somewhat greater; and dysentery and diarrhœa prevailed with greater severity only in Berar. The fall in cholera prevalence and mortality was general in almost every Indian province. The number of deaths from cholera fell from 762,695 in 1892 to 218,113 in 1893. In the Punjab the decline was from 76,000 to 639, in the Central Provinces from 40,000 to 557, and in Rajputana from nearly 27,000 to 314. Nothing serves to mark the marvellous difference between an epidemic and a non-epidemic cholera year better than figures of this sort. The great and abiding cause of mortality among the native population of India is fever, or what is returned as such. The total mortality from this cause is so enormous that it dwarfs that from all other causes.

There is an important memorandum, illustrated by a diagrammatic map, on the influence of railways in the dissemination of cholera, by Surgeon-Major J. Lewtas, M.D., officiating statistical officer to the Government of India in the sanitary and medical departments. He finds, as the result of a very careful and elaborate inquiry, that there is no ground for such a belief. Cholera is not more frequently manifested or more rapidly carried about from place to place than it was in pre-railway days, nor does cholera follow the lines of railway. If railways were the means of disseminating cholera they would obviously carry it in any direction indifferently, which they do not. Of course, cases of cholera may be thus carried, but they do not seem to have any influence on the course of an epidemic. In the Bengal Presidency the direction of an epidemic is always upwards—towards the north-west frontier; an epidemic moving downwards is unknown.

THE ROYAL COLLEGE OF PHYSICIANS OF LONDON.

THE extraordinary meeting of the Fellows for the purpose of the annual election of President was held on the 8th inst. The President, Sir J. Russell Reynolds, opened the proceedings by a few well-chosen remarks of sympathy at the loss sustained by the profession and the Royal College of Surgeons of England in the death of Mr. J. Whitaker Hulke, whose sterling characteristics he admirably sketched. The President then proceeded to deliver his annual address. The College roll now contained the names of 303 Fellows, 497 Members, 5 Licentiates prior to 1859, 12 extra-Licentiates, and 5970 Licentiates. Six Fellows had died during the past year—viz., Drs. Brown-Séquard, Little, Sturges, Withers Moore, Bisset Hawkins, and Hack Tuke. Mention was made of the inspection of the examinations by the General Medical Council and of matters of finance, the latter including the attempt of the Inland Revenue to make the College amenable to the Corporation Duty (1885), from which the College claimed exemption in consideration of its function as an educational body. The claim was under consideration, but would be pressed further, if necessary. In referring to the award of the Moxon Medal to Sir W. Jenner, the President observed that it was a remarkable circumstance that this medal, founded in honour of one of the most distinguished Fellows, should have been awarded to two physicians of whom he was young enough to have been the pupil—viz., Sir A. Garrod and Sir W. Jenner. The acquisition of the portrait of Sir A. Clark, painted by Mr. R. Lehmann, was referred to, and the munificent foundation of the Weber-Parkes Prize and Medals by Dr. Hermann Weber suitably acknowledged, as also was the gift of the Goldsmiths' Company to further researches on the antitoxin treatment of diphtheria. The lectures delivered at the College during the past year were enumerated, and the work of the Committee on the Nomenclature of Diseases stated to be far advanced. As regards the University of London, the President said that there was good reason to hope that the subject of the appointment of a Statutory Commission would be brought into the House of Lords after Easter. The conferment of a knighthood upon Dr. J. C. Bucknill, and of baronetcies upon Dr. John Williams and Dr. Russell Reynolds, was also mentioned. The President then proceeded to give obituary sketches of the deceased Fellows, and of Dr. Greenhill, a distinguished Member of the College who had declined the Fellowship when offered to him. At the close of the address a vote of thanks to the President was unanimously adopted on the motion of Sir R. Quain, seconded by Sir Dyce Duckworth.

The election of President was then taken, when it was found that Sir J. Russell Reynolds had received 76 votes, Dr. Wilks 2, Dr. Bastian 1, and Sir A. Garrod 1, there being eighty-one Fellows present and eighty voting.

Sir J. Russell Reynolds was then inducted into office by the Senior Censor (Dr. Latham) and having made the declaration returned thanks to the Fellows for having chosen him for the third time to preside over the College.

On the motion of the Treasurer, seconded by the Senior Censor, it was resolved that the College undertake the expenses attending the publication of the biography of Sir Henry Halford, formerly President of the College, which had been prepared by Dr. Munk, the librarian.

Communications were read from the Royal College of Surgeons of England relative to the representation of the Royal College of Physicians at the memorial service held at St. James's Church, Piccadilly, on the occasion of the funeral of the late Mr. Hulke; and also a letter from Mr. Wilmott, on behalf of Mrs. Hulke, expressing her sense of the sympathy shown by the College in her bereavement.

Dr. Henry de Fonmartin having resigned his Membership on account of his undertaking practice at Montpelier under conditions which would require him to dispense medicines, the resignation was accepted by the College.

The alteration in By-laws CLXII. and CLXIII. was moved for the second time by the Registrar and adopted.

A report from the Committee of Management embodying the substance of a reply to the report of the Inspector of the General Medical Council upon the examination for the diploma of Public Health was received. Dr. Heron moved that the

report be referred back to the committee for re-consideration and amendment. The motion was seconded by Dr. Thorne Thorne and the discussion upon it shared in by Sir Dyce Duckworth, Dr. Stevenson, and Dr. Norman Moore. Dr. Heron's amendment was carried by 20 votes to 12.

A supplementary report from the Committee of Management, recommending that Mr. Thomas Cooke's Course of Operative Surgery be recognised as fulfilling the requirements of the Regulations for the present year on the same conditions as heretofore, was adopted, and the Comitia adjourned.

THE HEALTH OF THE ITALIAN ARMY.

To the *Ispettorato di Sanità Militare* our thanks are due for a report on the health of the Italian army in 1893—a report which may be described as more than ever satisfactory, the improvement registered in 1892 being more than maintained.

The admissions into hospital for 1893 were 80,208—a figure which includes 11,468 whose admission was renewed for "continuazione di cura"; so that, these being deducted, the number of troops on the sick list was really 68,744.

Those admitted into the military hospitals, the garrison infirmaries, and the special infirmaries were 78,132, of whom 2336 came from other hospitals. The number, therefore, of admissions from the corps shrinks to 75,796, comprising 104 accommodated in canvas casual quarters, and 6708 admitted "in osservazione."

The admissions into convalescent quarters were 1733, of whom 1629 had been transferred thither from the hospitals and 104 contributed by the corps.

In the civil hospitals the admissions of troops amounted to 13,032, besides 59 coming from the other hospitals. Among them were 88 who had to be accommodated in divers lunatic asylums, as well for cure as to be kept under surveillance ("in osservazione").

The greatest absolute number of troops admitted into the civil hospitals was in the division of Leghorn—a priority, however, which proportionally to the respective mean force, belongs to the division of Perugia. The smallest number of admissions under this head is contributed by Turin.

The greatest contingent of patients came from the field artillery; next in order come the infantry of the line, the cavalry, "i distretti" (district service), the artillery in forts, the engineers, and the "bersaglieri." The smallest contingent was that of the carabineers. As a whole, the mean proportion of disease and of days under treatment in 1893 was lower than that of the preceding quadriennium.

With regard to the months in which the number of soldiers on the sick list was greatest the minimum was reached in February and the maximum in March and April; in May the increase began again to diminish, and continued in that direction, save in July, when a slight rise was noticed, due to the greater fatigue of the soldiers in the summer exercises. The minimum of disease was in November. The mortality also was at its highest in April and at its lowest in February.

The accentuation of disease in March and April, with the consequent exceptional mortality, is due to the arrival of the recruits, who in the first month of their service give always a large contingent of invalids. From the report, however, we gather that on the whole in 1893 the sanitary conditions of the army were in all respects better than throughout the whole preceding quadriennium.

The military divisions, taken singly, presented no slight difference in the mean proportions of the patients admitted, of the dead, and of the "riformati" (those dismissed the service for illness), per 1000 of the respective mean force. Taking the statistics of the last five years, we gather that the mean of sickness in all the years was exceeded in the divisions of Perugia, Rome, Naples, and Bari; that it was never attained in the divisions of Turin, Milan, Brescia, and Genoa; that in 1893 that mean was exceeded in the divisions of Ancona, Chieti, Rome (Sardinia), Perugia, Naples, Bari, Catanzaro, and Messina; and that all the other divisions remained "disotto" (under). The maximum of sickness was still maintained by the division of Perugia, and the minimum by that of Genoa.

As to the different arms of the service, the greatest contingent of maladies belongs to the infantry, after which comes the fort artillery ("artiglieria da fortezza"), while for surgical operations the cavalry and field artillery had the pre-eminence. The cavalry also had the greatest number of eye diseases. For venereal diseases the most prominent were the foraging companies ("compagnie di sussistenza"), the artisan companies of the artillery, and the engineers. The minimum was presented by the Alpine corps.

In 1893 the maladies of the respiratory organs were under the average (except in the case of pneumonia); as were also enteric fever, measles, most fevers and cachexiæ, influenza, articular rheumatism, and venereal and syphilitic ailments. An augmentation, however, was shown in scarlet fever, infective cerebro-spinal meningitis, with the addition of some cases of Asiatic cholera, this latter being wholly absent in 1892. Infective cerebro-spinal meningitis appeared with the arrival of the recruits of the various corps.

The number of deaths among the troops during 1893 was 1412, or in the proportion of 6·6 per 1000 of the mean force; hence again a diminution of 7·1 per 1000.

Mortality above the collective average was shown by the sanitary companies, the "distretti," the cavalry, and the royal carabineers; the same mean was not reached by the foraging companies, the Alpine corps, the "bersaglieri," the artillery, the engineers, and the military penal establishments. The maximum was found in the sanitary companies, the minimum in the foraging companies. The mortality in 1893 was below the average in the infantry, the "bersaglieri," the cavalry, the artillery, the engineers, and the military penal establishments, and above it in the other corps.

In 1893, for every month there was a lower mortality than that of 1892, except for March, April, July, and October. April furnished the greatest number of deaths, February the least. The greater mortality of April was caused by the arrival of the recruits called in March.

In the military divisions the mean of the mortality was exceeded in the divisions of Alessandria, Cuneo, Brescia, Piacenza, Genoa, Ancona, Chieti, Rome, Perugia, Salerno, Bari, and Palermo. In all the other divisions, including the island of Sardinia, the mortality was below the mean. The maximum death-rate was reached by the division of Bari, and the minimum by that of Ravenna.

"POST-INFLUENZAL MENINGITIS."

BY T. C. MAXIME,
OF THE FACULTÉ DE MÉDECINE, LYONS.

IT may be of interest to the readers of THE LANCET if I give a brief account of "post-influenzal meningitis," upon which Dr. Roque, Chef de Clinique to Professor Boudet of the Hôtel Dieu, Lyons, gave a learned exposition on March 19th. The subject is one which has been much discussed and reported upon of late by medical authorities, both in Paris and Berlin; but it is not a new point in post-influenzal affections, at any rate at Lyons, where it has been studied and described since 1889. In meningitis following influenza, which is rarely fatal, death hardly ever resulting from the influenzal affection itself, there is no lesion whatever to be found at the necropsy either in the brain or medulla. The affection is carried by the special action of the toxines secreted by the influenzal microbes producing inhibition phenomena, toxines which appear to have a very special predilection for the nerve centres.

Sometimes, though the event is rare, in cases of patients dying from meningitis which has supervened on influenza suppurating lesions of the brain and meninges are found, but these cases are not instances of post-influenzal meningitis strictly so called; it is rather a secondary affection brought out by influenza—a true meningitis preceded by influenza, and due to a streptococcus, staphylococcus, Eberth's bacillus, or more often to the pneumonococcus. But these cases of suppurative meningitis succeeding influenza are very rare, for out of the records of thousands of cases collated by Dr. Roque from various sources, there are only eleven deaths due to this sequel to "la grippe." Other cases belong to the category of post-influenzal meningitis strictly so called, which have a gravity of their own, symptoms quite similar to those of true meningitis, but none the less essentially very benign in nature, the brain not being injured by the progress of the malady itself. (It might have been damaged previously). Dr. Roque was induced to again put forth his views by the occurrence of a case under his care which unfortunately proved fatal, and in which a necropsy

was made. "This patient was admitted into the Hôtel Dieu a short time ago for influenza, having no special features and running a mild course, so that only the routine treatment was prescribed and no exceptional notice was taken of the case. But one day the patient was attacked with intermittent delirium, shortly afterwards becoming almost continuous, which together with other special symptoms attracted particular attention. Careful examination showed paralysis of the external recti muscles of the eyeballs, and very acute pains in the head, especially in the frontal region. Then the palsy involved the other recti. The patient had vomiting of cerebral origin, rigidity, retraction of the head, tenderness over the nuchal muscles, violent excitement requiring restraint at times, and, in a word, all the phenomena of meningitis; but it was remarkable that in spite of all this there was no marked rise of temperature, which ranged from 38° to 39° C. Suitable treatment was adopted and a favourable issue was foreseen, the condition, indeed, beginning to improve, when the patient's temperature suddenly rose and death ensued. One hardly knew what to think of this anomalous fact, and the necropsy was carefully made. Now although this patient had presented all the symptoms of meningitis there was absolutely no lesion found in the brain, no special change of any kind although several sections were made. Yet if, as stated above, post-influenzal meningitis be a very benign affection, why did this patient die, especially in this anomalous manner? The explanation is simple; it was because he had been attacked with a secondary cardiac affection, for the right auricle was found to be filled with a firm coagulum sending prolongations into the vessels and ventricle."

To sum up, post-influenzal meningitis is a benign affection which advances with violence, but which has not actually ever any serious issue. The meninges are not in the least injured, and the affection is brought about by the special action on the meninges of the toxines secreted by the influenzal microbes, and not by the microbes themselves; toxines for which the cerebro-spinal fluid probably serves as a receptacle, just as this fluid is one of the best culture media for microbes in local disease. This wholly peculiar action of the toxines of the influenzal microbes is, moreover, confirmed by the fact that the subjects of influenza who do not have post-influenzal meningitis do not escape presenting very marked symptoms of prostration, hypochondriasis, and depression (lasting a month or so)—phenomena which may be regarded as highly attenuated forms of the action on the nerve centres produced by the toxines.

Lyons.

THE CONGRESS OF MEDICINE IN MUNICH.

THE DEBATE ON THE ANTITOXIN TREATMENT OF DIPHTHERIA.

THIS Congress, which was opened on April 2nd, was attended by a great many leading medical men. The chair was taken by Professor Ziemssen of Munich. In his presidential address the chairman said that in his opinion at no period of the history of medicine were there such zeal and assiduity as at the present time. Undoubtedly progress in medical science depends mainly on the quiet work in hospital wards, in dissecting-rooms, and in laboratories; but periodical meetings enable the representatives of the different branches of medicine to compare their results and to know each other's views. It had always been, and he hoped always would be, the principle of this Congress to consider medicine as a unity, and therefore to maintain the connexion of internal medicine with surgery and pharmacology. The principal task of science was *rerum cognoscere causas*. Medicine had passed through the periods of anatomical and pathological research, and now had arrived at the era of etiology. We now try first to learn the causes of the different illnesses, and then to base the treatment on this knowledge. The antitoxin method, which would be the principal theme of this year's meeting, was a good specimen of the new era in the art of curing, as it was really founded on etiological examinations.

Baron von Feilitsch, the Prime Minister of Bavaria, then welcomed the Congress in the name of the Government, the Mayor Brunner in the name of the city of Munich, and Professor Beyer on behalf of the University. Prince Ludwig Ferdinand of Bavaria (who is himself a medical man) was elected honorary president, and Professor Wiederhofer (Vienna), Professor Bollinger (Munich), and Professor Leyden (Berlin) vice-presidents. Dr. Hochhaus (Kiel), Dr. Klemperer (Strasburg), and Dr. Sittmann (Munich) acted as secretaries. After these introductory proceedings the Congress began its work by a debate on the Antitoxin Treatment of Diphtheria, Professor Heubner delivering the first address.

Professor Heubner declared himself persuaded that a new epoch dated from Behring's invention. There was no doubt that Bretonneau's diphtheria was influenced by the remedy. Although he fully appreciated the difficulty of judging medical questions by the means of statistics, he pointed out that the mortality of diphtheria in Berlin had fallen from 44 per cent. to 21 per cent. The same fact was remarked wherever the remedy was used. It was, therefore, quite impossible for him to believe that this lowering of mortality was due to a weakness of the "genius epidemicus." In his statistics he had, of course, only reckoned the cases which were characterised as real diphtheria by the presence of Löffler's bacillus. All the other cases of diphtheria-like disease where this bacillus was not found he proposed to term "diphtheroid." The following effects of antitoxin could be noted:—1. That it has an influence on the course of the temperature; in diphtheria there is generally an access of fever after a few days of normal temperature. In antitoxin cases this has rarely ever happened. 2. That the pseudo-membranes are more easily loosened. 3. That the progression of the diphtheritic infiltration is stopped. The larynx can be kept free by early injections; but in cases where the larynx was already attacked the antitoxin did not prevent laryngo-stenosis. 4. That the intubation tube can be removed in a much shorter time. An absolute reduction in the number of albuminuric cases was not stated, but it was remarkable that the greater part of those patients who were injected on the first day remained free from albuminuria. The paralysis and the cardiac debility were not influenced by the remedy. The immunising effect was not at all sure and seemed to last only for a few weeks; the doses proposed by Dr. Behring appeared to be much too small for this purpose. Of complications Professor Heubner mentioned the angeioneurotic eruptions as caused by the serum; they did partly produce rather disagreeable symptoms. That the antitoxin could bring about nephritis was not all proved. He finally repeated his opinion that only a very early commencement of the treatment would give favourable results.

Professor Baginsky (Berlin) reported 525 injected cases. Whilst the average mortality of the illness in Berlin was 41 per cent., the antitoxin cases had only a death-rate of 15 per cent. In August and September, when the supply of serum failed, it rose again to 51 per cent. He had observed a great amelioration of the patient's general state, which, however, was only remarked on the second or third day after the injection, and a lowering of the temperature. In many cases he had seen a sudden stopping of the local affection; as in Professor Heubner's cases, the larynx, if not yet attacked, remained free; intubation could be performed with more success, so that tracheotomy could nearly totally be done away with. Sudden death from cardiac debility was very rare, and myocarditis was seldom found by post-mortem examination. The serum had no bad effect on the kidneys, nor was phenol present in the urine. It appears that carbolic acid, if combined with antitoxin, offers no phenolic reaction. Paralysis was, however, more frequent than before, maybe because more children remain alive. Sometimes suppuration at the place of the injection was observed, principally when the latter was made, not under the skin, but into the muscular substance. The rashes are not of great importance, and in diphtheria had occurred before the new method was used. He warmly recommended a continuance of the antitoxin treatment.

Professor Wiederhofer (Vienna) expressed the same opinion as Professor Heubner and Professor Baginsky.

Professor von Ranke (Munich) said that all his cases were of three or four days standing when treatment was commenced. Of 96 patients, 63 had still laryngo-stenotic symptoms. In 21 of these 63 cases laryngo-stenosis very soon disappeared; in 42 intubation was performed; of these 13 died. The intubation period was much shorter than before. He thought that the antitoxin was able to prevent the diphtheritic process from descending to the larynx and the lungs.

Dr. Kohts (Strasburg) said he had not seen very marked benefit, some cases excepted, where the local affection seemed to disappear more quickly than before.

Dr. Grawitz (Berlin) reported his experiments of *intravenous* injection of blood serum on rabbits and dogs. He had observed an extreme dilution of the blood, caused by the attraction of water from the tissues and the raising of the secretion of the kidneys. The *subcutaneous* injection of blood serum had the same effect. Patients who had been treated with antitoxin also showed an increase of water in the blood. After ten or twelve hours this hydræmic state passed away and was followed by a decrease of the quantity of water. Dr. Grawitz concludes from these facts that it was still an open question whether the action of the antitoxin depends only on the increase of succulence in the tissues or is a really antitoxic one.

Dr. Seitz (Munich) had had the same good results as Professor Heubner and others. He alluded to the alleged injurious effects of the serum and denied them to be of any importance. Like other observers, he had remarked an increase of the exanthemata, whether the serum was only prophylactically used or used as a cure.

Dr. Stintzing (Jena) was of quite a different opinion from the greater part of the physicians present. He warned the meeting to be very reserved in its judgment; it was, in his opinion, undeniable that diphtheria was now much milder than in any former year. He said it would be at least four or five years before he could give a definitive opinion about the efficacy of the new method.

Dr. Trump (Gratz) gave an account of his bacteriological investigations in diphtheria cases. He found three specimens of bacilli: (1) the genuine Löffler bacillus; (2) other bacilli which were not pathological; and (3) a so-called pseudo-diphtherial bacillus which in cultures resembled the Löffler bacilli, but if inoculated in animals appeared not to be pathological. He had stated: 1. That in children affected with diphtheria the real Löffler bacillus is present also on other mucous membranes, especially on the conjunctiva and on the vulva, without producing any pathological alterations. 2. That Löffler's bacillus remained a very long time alive. He had cultivated it from a child eighty-two days after the disease was over. The virulence, however, was weakened, so that it produced only a local irritation in a guinea-pig. He had found in the mucous membranes of the eye and the nose of children who had never had diphtheria the typical Löffler bacillus. As this was principally the case in hospital patients he was of opinion that the bacillus had been introduced there by patients who came back from the diphtheria ward. 3. From these facts he concluded that persons who themselves did not offer any symptoms of diphtheria can infect other people. This infection he understood as a mere contagious one. Therefore the disinfection of the patients' homes and goods is not sufficient to avoid the propagation of the disease; the latter can only be prevented by the immunisation of the patients themselves. For this purpose the immunising qualities of antitoxins would prove to be of the greatest use.

Dr. Rauchfuss (St. Petersburg) agreed with the other speakers about the good qualities of the antitoxin, but he mentioned that myocarditis was more frequent; perhaps that might be due to the fact that a greater number of patients remained alive.

The discussion being closed the Congress, on the proposition of Professor Heubner, adopted the following motion: That this meeting is of opinion that no harm had been done to the patients by the antitoxin treatment, that the majority of observers had seen good results, and that the experiments concerning immunisation were not yet sufficient and should be continued.

CHOLERA.

THE influence of season in connexion with cholera outbreaks and epidemics in countries where that disease is prevalent, such as India, is often very striking, and it has even been said to override every other influence. Be this as it may, it is a matter of ordinary observation that the cholera of any year is not a manifestation throughout each month of the year, but there is a succession of manifestations alternately with seasons of dormancy. The cholera cause is revitalised, renewed, or reproduced, and manifests itself with certain force at certain seasons, varying to some extent with its geography. A spring cholera and a monsoon and autumn cholera are recognised, for example, in India, and it very commonly happens in countries that have been invaded by an epidemic that a manifestation of its presence occurs about the end of March and at this season. We know that epidemic cholera has of late years prevailed in Russia; it has not yet died out there; it has only been dormant and hybernating, and the disease has of late manifested itself afresh, but mainly in a sporadic form in certain provinces and districts of that country. There have been some cases reported also in Turkey and Constantinople, and there has been a severe outbreak in the quarantine lazaretto of Camaran in the Red Sea. The first cases were reported about the end of last month. The lazaretto is at present occupied with numerous Mecca pilgrims, and a large number have recently passed through on their way to Djedda, to be soon followed by others—hence this outbreak may have much significance and importance. In another part of the East—namely, China—we learn that an outbreak of the disease among the Expeditionary Force is causing great anxiety to the Japanese Government.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

ELECTION OF PRESIDENT.

A QUARTERLY MEETING of the Council was held on the 4th inst., Mr. Reginald Harrison, the Senior Vice-President, being in the chair.

The Council then proceeded (as reported in our last issue) to the election of a President for the remainder of the collegiate year, the vacancy being caused by the death of Mr. J. Whitaker Hulke, F.R.S. Mr. Christopher Heath was elected. Mr. Harrison then vacated, and Mr. Heath took the chair.

The Committee for General Purposes recommended that the portraits of John and William Hunter presented by the Hunter Baillie family, which had been recently received, should be reframed, and this was agreed to.

The Jacksonian Prize for an essay on the Diagnosis and Surgical Treatment of Diseases of the Liver, Gall-bladder, and Biliary Ducts was adjudged to Mr. H. J. Waring, the author of the dissertation bearing the motto "Si torrere jecur, quæris idoneum." It was resolved that Mr. Waring should be requested to attend the next ordinary meeting of the Council on May 9th to receive the Jacksonian Prize.

Mr. Rivington, as chairman of the Jacksonian Committee, submitted two subjects for the Jacksonian Prize for the ensuing year, 1896, and the Council selected the following: "The Pathology, Diagnosis, and Treatment of Diseases of the Prostate Gland."

Two subjects were also submitted for the next Collegial Triennial Prize, and the Council selected "The arrangement and topography of the different parts of the gastro-intestinal canal in man, with special reference to the variations in their relation to the peritoneum and the occurrence of abnormalities; the subject to be illustrated from development and a comparison with the customary arrangement in other mammalian animals."

A report, dated March 18th, 1893, from the Committee of Management of the Conjoint Examining Board was read, dealing with the arrangements for the third and fourth examinations under the new regulations, and the suggested examination in ophthalmic medicine and surgery. These matters were then referred to a special committee, composed of the President and Vice-Presidents, Mr. Hutchinson, Mr. Bryant, Sir William MacCormac, Mr. T. Pickering Pick, Mr. Howse, Mr. Howard Marsh, and Mr. Morris. The report also dealt with the recognition of several institutions as places of instruction in chemistry, physics, practical chemistry, and biology, the recognition of a course of laboratory instruction in public health at the Westminster Hospital Medical School, and the recognition of the City of London Hospital for Diseases of the Chest as a place of study during the fifth year of the curriculum. These portions of the report were approved and adopted.

A report, dated March 8th, 1895, from the Laboratories Committee was read, approved, and adopted. It was as follows:—

1. *The work in diphtheria for the Metropolitan Asylums Board.*—(*a*) Examination of material for diagnosis. Since Jan. 1st 1145 specimens have been examined and reported

upon. In some cases the report is issued on the same day that the specimen arrives; but in the majority of cases the examination necessitates as much as twenty-four hours' work. An accurate record has been kept of the examination of each case, including the various organisms found. During the first seven weeks the director with two assistants examined all the cases, but since the third week in February Mr. Card has relieved the director of the superintendence of the microscopic examination of some of the specimens. The work goes on very smoothly, and is now being accomplished more rapidly than at first. The director has undertaken to report fully to the Metropolitan Asylums Board on every 500 cases examined. (*b*) The preparation of antitoxin serum. After some unavoidable delay the Metropolitan Asylums Board placed at the director's disposal stabling for fifteen horses at Tooting; four horses are being prepared, all of them are in good health, and in three cases the treatment is well advanced. As soon as these horses are ready the supply of serum will be ample, and it is intended that one or two reserve horses shall be prepared. It is probable that the serum will be ready for use at an early date.

2. *The Goldsmiths' Company's grant for researches on the antitoxin treatment of diphtheria, &c.*—The Committee, seeing their way to placing a certain quantity of antitoxic serum at the disposal of investigators, have for the purposes of experiment determined to make a grant of £100 to Dr. Sidney Martin for the purpose of working out the action of the antitoxic serum when used to counteract the effects of various poisons separated by him from the membrane and from the spleen in cases of diphtheria. This appears to the Committee to be a most important question, and one that must be settled before the mode of action of antitoxic serum can be understood, and they feel that no one can better undertake this work than Dr. Martin. The Committee have some other lines of research under consideration, on which they will fully report to the Colleges in due course.

A letter was read—signed by the President, Vice President, and Secretary of the Royal College of Surgeons in Ireland—expressing the regret of that College at the death of the President of the Royal College of Surgeons of England. It was moved and carried unanimously that the thanks of the Council be conveyed to the Royal College of Surgeons in Ireland for the kind words of sympathy contained in their letter.

A letter was read from the Registrar of the General Medical Council stating that Mr. Charles Tomes has been appointed by that Council as Visitor of the Dental Examinations of the College, and that he will visit and inspect these examinations during the present year.

Mr. Hutchinson moved: "That steps be taken to obtain busts of the late Sir William Savory, Bart., F.R.S., and the late Mr. J. W. Hulke, F.R.S." The matter was referred to a committee consisting of the President, Vice-Presidents, and Past Presidents to consider and report.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

In thirty-three of the largest English towns 6611 births and 4280 deaths were registered during the week ending April 6th. The annual rate of mortality in these towns, which had declined in the four preceding weeks from 35·0 to 23·4 per 1000, further fell last week to 21·1. In London the rate was equal to 19·0 per 1000, while it averaged 22·6 in the thirty-two provincial towns. The lowest rates in these towns were 10·9 in Croydon, 13·1 in Huddersfield, 15·2 in Plymouth, 15·4 in Nottingham, and 15·7 in West Ham; the highest rates were 26·9 in Birmingham, 27·0 in Blackburn, 28·5 in Oldham, 31·9 in Preston, and 33·0 in Burnley. The 4280 deaths included 274 which were referred to the principal zymotic diseases, against 314 in each of the two preceding weeks; of these, 93 resulted from whooping-cough, 53 from measles, 51 from diphtheria, 38 from diarrhœa, 21 from scarlet fever, 17 from "fever" (principally enteric), and one from small-pox. No fatal case of any of these diseases occurred last week either in Bristol, Bradford, or Birkenhead; in the other towns they caused the lowest death-rates in Newcastle-upon-Tyne, Gateshead, and Huddersfield; and the highest rates in Manchester, Cardiff, Salford, and Burnley. The greatest mortality from measles occurred in Cardiff, Sheffield, and Bolton; and from whooping-cough in Norwich, Salford, Preston, Burnley, and Portsmouth. The mortality from scarlet fever and from "fever" showed no marked excess in any of the thirty-three large towns. The 51 deaths from diphtheria included 23 in London, 5 in Birmingham, 4 in Manchester, and 3 in West Ham. One fatal case of small-pox was registered in Derby, but not one in London or any other of the large towns. There were 53 cases of small-pox under treatment in the Metropolitan Asylum Hospitals and in the Highgate Small-pox Hospital on Saturday last, April 6th, against 57, 58, and 55 at the end of the three preceding weeks; 7 new cases were admitted during the week, against 12, 14, and 10 in the three preceding weeks. The number of scarlet fever patients in the Metropolitan Asylum Hospitals and in the London Fever Hospital at the end of the week was 1519, against 1615, 1587, and 1555 on the three preceding Saturdays; 143 new cases were admitted during the week, against 184 and 161 in the two preceding weeks. The deaths referred to diseases of the respiratory organs in London, which had declined from 1448 to 497 in the five preceding weeks, further fell to 427 last week, but were 17 above the corrected average. The causes of 69, or 1·6 per cent., of the deaths in the thirty-three towns were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in Bristol, Salford, Leeds, Newcastle-upon-Tyne, and in eight other smaller towns; the largest proportions of uncertified deaths were registered in Birmingham, Liverpool, Sheffield, and Hull.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had declined in the five preceding weeks from 42·8 to 25·4 per 1000, further fell to 24·7 during the week ending April 6th, but exceeded by 3·6 per 1000 the mean rate during the same period in the thirty-three large English towns. The rates in the eight Scotch towns ranged from 18·9 in Perth and 20·0 in Edinburgh, to 26·6 in Dundee and 30·3 in Aberdeen. The 713 deaths in these towns included 25 which were referred to whooping-cough, 22 to measles, 17 to diarrhœa, 3 to small-pox, 3 to "fever," 2 to diphtheria, and 2 to scarlet fever. In all, 74 deaths resulted from these principal zymotic diseases, against 115 and 90 in the two preceding weeks. These 74 deaths were equal to an annual rate of 2·6 per 1000, which was 1·3 above the mean rate last week from the same diseases in the thirty-three large English towns. The fatal cases of whooping-cough, which had been 27 and 26 in the two preceding weeks, were 25 last week, of which 13 occurred in Glasgow, 5 in Dundee, and 4 in Leith. The deaths referred to measles, which had been 48, 56, and 35 in the three preceding weeks, further declined to 22 last week, and included 7 in Edinburgh and 7 in Aberdeen. The 17 fatal cases of diarrhœa exceeded by 3 the number in the preceding week, and included 9 in Glasgow. The 3 deaths referred to different forms of "fever" corresponded with the number in the preceding week, and included 2 in Dundee. The fatal cases of diphtheria, which had been 9 and 5 in the two preceding weeks, further declined to 2 last week. Of the 3 deaths from small-pox, 2 were recorded in Glasgow and 1 in Edinburgh. The deaths referred to diseases of the respiratory organs in these towns, which had been 313 and 199 in the two preceding weeks, further declined to 189 last week, but were 74 above the number in the corresponding week of last year. The causes of 62, or nearly 6 per cent., of the deaths in the eight towns last week were not certified.

HEALTH OF DUBLIN.

The death-rate in Dublin, which had increased from 42·4 to 48·6 per 1000 in the three preceding weeks, declined again to 43·3 during the week ending April 6th. During the thirteen weeks of last quarter the death-rate in the city averaged 37·1 per 1000, the rate during the same period being 26·0 in London and 20·5 in Edinburgh. The 290 deaths registered in Dublin during the week under notice showed a decline of 36 from the number in the previous week, and included 11 which were referred to the principal zymotic diseases, against 7 and 12 in the two preceding weeks; of these, 4 resulted from whooping-cough, 3 from small-pox, 3 from diarrhœa, 1 from "fever," and not one either from measles, scarlet fever, or diphtheria. These 11 deaths were equal to an annual rate of 1·6 per 1000, the zymotic death-rate during

MONTHLY ANALYSIS OF SICKNESS AND MORTALITY STATISTICS IN LONDON—MARCH, 1895.

(Specially compiled for THE LANCET.)

Sanitary areas.	Estimated population in the middle of 1895.	Notified Cases of Infectious Disease.											Deaths from Principal Infectious Diseases.										Deaths from all causes.	Death-rate per 1000 living.	Deaths of Infants under one year to 1000 births.
		Small-pox.	Scarlet fever.	Diphtheria.*	Typhus fever.	Enteric fever.	Other continued fevers.	Puerperal fever.	Erysipelas.	Cholera.	Total.	Annual rate per 1000 persons living.	Small-pox.	Measles.	Scarlet fever.	Diphtheria.†	Whooping-cough.	Typhus fever.	Enteric fever.	Other continued fevers.	Diarrhœa.	Total.	Annual rate per 1000 persons living.			
LONDON	**4,382,346**	**41**	**880**	**527**	**2**	**119**	**4**	**13**	**369**	**—**	**1955**	**5·8**	**1**	**77**	**38**	**114**	**203**	**1**	**18**	**1**	**55**	**508**	**1·5**	**10,107**	**30·0**	**193**
West Districts.																										
Paddington	122,756	2	6	5	—	5	—	1	6	—	25	2·7	—	—	1	3	1	—	—	—	2	7	0·7	270	28·7	161
Kensington	167,671	1	24	23	—	2	—	1	12	—	63	4·9	—	1	—	4	5	—	1	—	5	16	1·2	346	26·9	192
Hammersmith	108,429	—	23	14	—	5	—	—	6	—	48	5·8	—	1	—	1	4	—	2	—	1	9	1·1	239	28·7	226
Fulham	117,745	1	35	21	—	—	—	—	6	—	63	7·0	—	2	2	3	5	—	—	—	2	14	1·6	272	30·1	295
Chelsea	99,930	—	16	7	—	2	—	—	8	—	33	4·3	—	1	1	1	3	—	1	—	2	9	1·2	247	32·2	214
St. George Hanover-square	74,037	—	13	11	—	1	—	—	6	—	31	5·5	—	1	—	1	6	—	—	—	—	8	1·4	179	31·5	253
Westminster	54,003	—	6	14	—	2	—	—	3	—	25	6·0	—	—	—	3	2	—	—	—	—	5	1·2	145	35·0	283
St. James Westminster	23,149	—	4	6	—	—	—	—	1	—	11	6·2	—	—	—	1	3	—	—	—	—	4	2·3	55	31·0	416
North Districts.																										
Marylebone	137,392	9	28	12	—	5	—	—	7	—	61	5·8	1	1	2	2	8	—	1	—	1	16	1·5	367	34·8	176
Hampstead	77,592	—	20	7	—	1	—	—	5	—	33	5·5	—	2	1	—	2	—	—	—	—	5	0·8	124	20·6	185
St. Pancras	233,543	—	60	24	—	5	—	—	35	—	124	6·9	—	5	3	6	17	—	—	—	2	33	1·8	562	31·4	239
Islington	335,929	—	95	18	2	6	—	3	26	—	150	5·8	—	2	9	3	13	1	1	—	4	33	1·3	693	26·9	158
Stoke Newington	35,274	—	4	2	—	—	—	—	2	—	8	3·0	—	—	—	—	—	—	—	—	—	—	—	62	22·9	224
Hackney	215,623	—	35	23	—	3	—	—	17	—	78	4·7	—	7	1	3	8	—	—	—	3	22	1·3	474	28·7	165
Central Districts.																										
St. Giles	37,654	1	2	2	—	1	—	—	2	—	8	2·8	—	1	—	—	2	—	—	—	—	3	1·0	101	35·0	107
St. Martin-in-the-Fields	13,526	—	2	2	—	—	—	—	1	—	5	4·8	—	—	—	3	—	—	—	—	—	3	2·9	32	30·8	600
Strand	22,586	—	8	4	—	1	—	—	1	—	14	8·1	—	—	1	1	2	—	—	—	—	4	2·3	70	40·5	280
Holborn	32,188	4	3	3	—	1	—	—	5	—	16	6·5	—	3	—	—	—	—	—	—	1	4	1·6	97	39·3	234
Clerkenwell	66,036	—	12	6	—	5	—	—	8	—	33	6·6	—	—	1	1	3	—	1	—	1	7	1·4	171	34·3	211
St. Luke	40,763	—	3	3	—	—	—	—	6	—	12	3·8	—	—	1	—	4	—	—	—	—	5	1·6	107	34·2	122
City of London	33,624	—	2	1	—	1	—	—	1	—	5	1·9	—	—	—	1	—	—	—	—	—	1	0·4	79	30·5	140
East Districts.																										
Shoreditch	122,932	—	13	8	—	—	—	—	9	—	30	3·2	—	7	1	3	11	—	—	—	—	22	2·3	331	35·1	226
Bethnal Green	130,061	1	20	13	—	3	—	1	21	—	59	5·9	—	1	—	4	2	—	—	—	2	9	0·9	309	31·0	201
Whitechapel	75,820	—	9	11	—	—	—	—	2	—	22	3·8	—	2	—	2	—	—	—	—	1	5	0·9	167	28·7	122
St. George-in-the-East	45,227	—	8	4	—	2	—	1	5	—	20	5·8	—	1	—	1	4	—	—	—	1	7	2·0	121	34·9	166
Limehouse	56,885	—	20	10	—	3	—	—	5	—	38	8·7	—	7	—	1	6	—	1	—	—	15	3·4	152	34·8	240
Mile End Old Town	108,443	—	27	18	—	1	—	—	10	—	56	6·7	—	1	—	8	4	—	—	—	—	13	1·6	211	25·4	137
Poplar	171,230	—	54	27	—	10	1	—	19	—	111	8·5	—	6	2	5	11	—	—	—	3	27	2·1	402	30·6	171
South Districts.																										
St. Saviour Southwark	26,570	—	1	3	—	2	—	—	—	—	6	2·9	—	—	—	—	—	—	—	—	1	1	0·5	68	33·4	174
St. George Southwark	60,168	1	6	4	—	2	—	—	5	—	18	3·9	—	—	—	2	3	—	—	—	—	5	1·1	186	40·3	252
Newington	119,358	—	15	6	—	3	—	—	12	—	36	3·9	—	3	1	—	13	—	1	—	2	20	2·2	353	38·6	254
St. Olave Southwark	13,065	—	—	2	—	—	—	—	—	—	2	2·0	—	—	—	—	1	—	1	—	1	3	3·0	32	32·0	212
Bermondsey	83,861	1	17	5	—	2	—	—	5	—	30	4·7	—	—	—	1	3	—	1	—	1	6	0·9	208	32·3	191
Rotherhithe	40,713	10	20	8	—	1	—	—	6	—	45	14·4	—	1	—	3	3	—	—	—	1	8	2·6	92	29·5	179
Lambeth	284,883	1	43	22	—	10	3	3	27	—	109	5·0	—	2	2	5	24	—	—	1	5	39	1·8	682	31·2	180
Battersea	165,130	1	39	26	—	3	—	2	9	—	80	6·3	—	11	1	7	7	—	1	—	2	29	2·3	349	27·6	210
Wandsworth	185,956	—	53	26	—	8	—	—	18	—	105	7·4	—	5	1	3	—	—	2	—	1	12	0·8	360	25·2	144
Camberwell	252,737	1	68	53	—	16	—	—	25	—	163	8·4	—	—	3	13	5	—	2	—	4	27	1·4	552	28·5	230
Greenwich	175,183	7	34	54	—	5	—	—	13	—	113	8·4	—	3	1	17	8	—	—	—	4	33	2·5	400	29·8	180
Lewisham (excluding Penge)	82,410	—	5	9	—	1	—	1	8	—	24	3·8	—	—	—	—	1	10	—	—	1	12	1·9	182	28·8	213
Woolwich	42,768	—	3	1	—	—	—	—	1	—	5	1·5	—	—	—	—	—	—	—	—	—	—	—	78	23·8	173
Lee	38,832	—	6	3	—	—	—	—	3	—	12	4·0	—	—	1	—	—	—	1	—	1	3	1·0	70	23·5	182
Plumstead	61,494	—	18	4	—	—	—	—	2	—	24	5·1	—	—	2	1	—	—	—	—	—	4	0·8	110	23·3	171
Port of London	—	—	—	—	—	1	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

* Including 31 cases of membranous croup.

† Including deaths from membranous croup.

the same period being 1·4 in London and 2·3 in Edinburgh. The 4 fatal cases of whooping-cough exceeded the number recorded in recent weeks. The deaths referred to small-pox, which had been 4, 5, and 1 in the three preceding weeks, rose again to 3 last week. The three fatal cases of diarrhœa corresponded with the number in the previous week, while the mortality from "fever" showed a marked decline. The 290 deaths registered in Dublin last week included 44 of infants under one year of age and 111 of persons aged upwards of sixty years; the deaths both of infants and of elderly persons almost corresponded with the numbers in the previous week. Three inquest cases and 3 deaths from violence were registered; and 96, or nearly a third, of the deaths occurred in public institutions. The causes of 17, or nearly 6 per cent., of the deaths in the city last week were not certified.

VITAL STATISTICS OF LONDON DURING MARCH, 1895.

IN the accompanying table will be found summarised complete statistics relating to sickness and mortality during March in each of the forty-three sanitary areas of London. With regard to the notified cases of infectious diseases in the metropolis during last month, it appears that the number of persons reported to be suffering from one or other of the nine diseases specified in the table was equal to 5·8 per 1000 of the population, estimated at 4,392,346 persons in the middle of this year. In the three preceding months the rates had been 8·4, 7·0, and 5·9 per 1000 respectively. Among the various sanitary areas the rates were considerably below the average in Paddington, St. Giles, City of London, St. Saviour Southwark, St. Olave Southwark, and Woolwich; while they showed the largest excess in Fulham, Strand, Limehouse, Poplar, Rotherhithe, Camberwell, and Greenwich. The prevalence of small-pox in London showed a slight decline during March, 41 cases being notified during the month, including 10 in Rotherhithe, 9 in Marylebone, 7 in Greenwich, and 4 in Holborn sanitary areas. The Metropolitan Asylum Hospitals contained 54 small-pox patients at the end of March, against 16, 51, and 66 at the end of the three preceding months; the weekly admissions averaged 11, against 3, 10, and 15 in the three preceding months. The prevalence of scarlet fever in London during March showed a slight decline from that recorded in the preceding month; this disease was proportionally most prevalent in Fulham, Strand, Limehouse, Poplar, Rotherhithe, Wandsworth, Camberwell, and Plumstead sanitary areas. The Metropolitan Asylum Hospitals contained 1485 scarlet fever patients at the end of March, against 1865, 1633, and 1569 at the end of the three preceding months; the weekly admissions averaged 145, against 171, 148, and 141 in the three preceding months. The prevalence of diphtheria in London showed a slight increase during March; among the various sanitary areas this disease showed the highest proportional prevalence in Fulham, Limehouse, Mile End Old Town, Poplar, Rotherhithe, Battersea, Camberwell, and Greenwich. There were 435 cases of diphtheria under treatment in the Metropolitan Asylum hospitals at the end of March, against 521, 515, and 461 at the end of the three preceding months; the weekly admissions averaged 62, against 93, 71, and 50 in the three preceding months. The prevalence of enteric fever in London showed a slight decline during the month under notice; among the various sanitary areas this disease showed the highest proportional prevalence in Poplar and Camberwell. Erysipelas was proportionally most prevalent in St. Pancras, Holborn, and Rotherhithe sanitary areas. The 13 cases of puerperal fever notified during March included 3 in Islington, 3 in Lambeth, and 2 in Battersea sanitary areas.

The mortality statistics in the accompanying table relate to the deaths of persons actually belonging to the various metropolitan sanitary areas, the deaths occurring in the institutions of London having been distributed among the different sanitary areas in which the patients had previously resided. During the four weeks ending Saturday, March 30th, the deaths of 10,107 persons belonging to London were registered, equal to an annual rate of 30·0 per 1000, against 17·7, 18·3, and 30·3 in the three preceding months. This high rate was principally due to the epidemic prevalence of influenza. The lowest death-rates during March in the various sanitary areas were 20·8 in Hampstead, 22·9 in Stoke Newington, 23·3 in Plumstead, 23·5 in Lee, 23·8 in Woolwich, and 25·2 in Wandsworth; the highest rates were 35·0 in Westminster and St. Giles, 35·1 in Shoreditch, 38·6 in Newington, 39·3 in Holborn, 40·3 in St. George Southwark, and 40·5 in Strand. During the four weeks of March 508 deaths were referred to the principal zymotic diseases in London; of these, 203 resulted from whooping-cough, 114 from diphtheria, 77 from measles, 55 from diarrhœa, 38 from scarlet fever, 20 from different forms of "fever," (including 1 from typhus fever, 18 from enteric fever, and 1 from an ill-defined form of fever), and 1 from small-pox. These 508 deaths were equal to an annual rate of 1·5 per 1000, against 1·6 and 1·5 in the two preceding months. No fatal case of any of these diseases was recorded last month in Stoke Newington or in Woolwich; in the other sanitary areas they caused the lowest death-rates in Paddington, Hampstead, City of London, St. Saviour, Southwark, Wandsworth, and Plumstead; and the highest rates in St. Martin-in-the-Fields, Limehouse, St. Olave Southwark, Rotherhithe, and Greenwich. Only 1 fatal case of small-pox was registered in London during the month under notice, the corrected average in the corresponding periods of the ten preceding years being 13; this fatal case belonged to Marylebone sanitary area. The 77 deaths referred to measles were little more than a third of the corrected average number; among the various sanitary areas this disease showed the highest proportional fatality in Hackney, Holborn, Shoreditch, Limehouse, Poplar, and Battersea. The 38 fatal cases of scarlet fever were 23 below the corrected average number; the mortality from this disease showed no marked excess last month in any of the sanitary areas. The 114 deaths from diphtheria almost corresponded with the corrected average number; this disease showed the highest proportional fatality in Westminster, St. Martin-in-the-Fields, Mile End Old Town, Camberwell, and Greenwich sanitary areas. The 203 fatal cases of whooping-cough were 84 below the corrected average number; among the various sanitary areas this disease showed the highest proportional fatality in St. James Westminster, St. Luke, Shoredith, Limehouse, Newington, Lambeth, and Lewisham. The 18 deaths referred to enteric fever were little more than half the corrected average number; there was no marked excess of "fever" mortality last month in any of the sanitary areas. The 55 deaths from diarrhœa were within one of the corrected average number. In conclusion, it may be stated that the mortality in London during the month under notice from these principal zymotic diseases was as much as 38 per cent. below the average.

Infant mortality in London during March, measured by the proportion of deaths under one year of age to registered births, was equal to 193 per 1000, and considerably exceeded the average. Among the various sanitary areas the lowest rates of infant mortality were recorded in St. Giles St. Luke, City of London, Whitechapel, Mile End Old Town, and Wandsworth; and the highest rates in Fulham, Westminster, St. James Westminster, St. Martin-in-the-Fields, Strand, and Newington.

THE SERVICES.

ARMY MEDICAL STAFF.

SURGEON-MAJOR SIR JAMES R. A. CLARK, Bart., F.R.C.S. Edin., retires from the service, receiving a gratuity. Surgeon-Captain Vere E. Hunter to be Surgeon-Major. Surgeon-Captain Frederick T. Skerrett, F.R.C.S.I., from half-pay, to be Surgeon-Captain, vice A. Wright, seconded.

INDIA AND THE INDIAN MEDICAL SERVICES.

The following appointments are announced:—10th Bombay Infantry: Surgeon-Major Adey to the Medical Charge, vice Surgeon-Captain Arnim, transferred permanently to the Civil Department, and Surgeon Lieutenant B. H. F. Leumann, M.B., Officiating Medical Officer, to act as Civil Surgeon. 29th Bombay Infantry: Surgeon-Captain Heath to the Medical Charge, vice Surgeon-Major Adey, transferred. Surgeon-Captain T. W. Shaw, M.B., (Bombay), is confirmed in the appointment of Medical Officer 1st Regiment Central India Horse, and of the Goona Political Agency. Surgeon-Majors H. McCalman and D. C. Davidson have respectively delivered over and received charge of the Dharwar Prison, and Surgeon-Captain S. E. Prall, M.B., B.S., and Brigade-Surgeon-Lieutenant-Colonel C. T. Peters, M.B., have delivered over and received charge of the Bijapur Prison. Surgeon-Major A. Milne (Bombay Establishment), Deputy Assay Master, Calcutta, is transferred to Bombay as

Deputy Assay Master. Surgeon-Captain Whitcombe, on return from leave of Surgeon-Major Maitland, has been transferred to general duty, Poona.

NAVAL MEDICAL SERVICE.

Staff-Surgeon H. X. Browne is appointed to the *President*.

ARMY MEDICAL RESERVE OF OFFICERS.

Surgeon-Major Arthur O. Wiley, having resigned his Volunteer appointment, ceases to be an officer of the Army Medical Reserve of Officers. Surgeon-Captain William Chalmers-Cowan to be Surgeon-Major.

MILITIA MEDICAL STAFF.

Surgeon-Lieutenant-Colonel C. Whipple, 3rd Battalion the Devonshire Regiment, resigns his commission; also is permitted to retain his rank and to wear the prescribed uniform on his retirement.

VOLUNTEER CORPS.

Rifle: 1st Volunteer Battalion the Duke of Cornwall's Light Infantry: Surgeon-Lieutenant J. W. Haughton is appointed Second Lieutenant. Surgeon-Captain (Honorary Surgeon-Major) R. C. M. Pooley resigns his commission; also is permitted to retain his rank, and to continue to wear the uniform of the battalion on his retirement. 2nd Volunteer Battalion the King's (Shropshire) Light Infantry: Surgeon-Captain C. H. Gwynn, M.D., to be Surgeon-Major. 1st (Ross Highland) Volunteer Battalion Seaforth Highlanders (Ross-shire Buffs, the Duke of Albany's): Surgeon-Lieutenant C. Mackenzie, M.B., resigns his commission.

OVERCROWDING AND DEFECTIVE VENTILATION IN RELATION TO PNEUMONIA.

The writer of the article on the "Sanitary State of the German Army" in the March number of *The Medical Magazine*, adverting to the prevalence of pneumonia in the armies of Germany and France and the alleged infectious nature of the disease, alludes to his own experience of this so-called infectious pneumonia during the war in South Afghanistan. Attendants on the sick were freely attacked, and the general opinion then was that the malady was most infectious. The men were greatly overcrowded and every aperture was closed to keep out the cold, which was extreme, so that the atmosphere in which they lived was very foul. The disease rapidly spread, and under these conditions no doubt manifested infectious properties; but the writer adds that, given pure air and free ventilation, he is convinced there is no danger of the disease spreading by reason of propinquity alone from the sick to the healthy. There is no doubt that overcrowding and foul air are very powerful predisponents, at any rate, to attacks of pneumonia in winter and early spring, especially among those who have previously suffered from malarious disease. The lungs in such subjects become congested, inflamed, and hepatised with almost the ease and rapidity with which the spleen swells in attacks of ague. This has been the experience of medical officers serving with troops in India and in campaigns in that country; the disease may spread in foul and unventilated tents and buildings with the apparent rapidity of typhus. A great many years ago there was an outbreak of pneumonia in the ironclads of the Mediterranean fleet, almost resembling an epidemic, attributable, no doubt, to a similar cause—bad ventilation. An infection can apparently be manufactured under certain conditions.

SURGEON-GENERAL SAVILLE MARRIOTT PELLY, C.B., F.R.C.S. ENG.

Surgeon-General S. M. Pelly, who died suddenly on the 3rd inst. at his residence, Lee, aged seventy-six, retired in 1870 with the rank of Inspector-General. He was attached to the Bombay Army and served with the Sind Irregular Horse during the campaign of 1844-45 against the border tribes of Cutchee. He was present at the capture of Shahpoor, for which he was mentioned in the despatches. He also served under Sir C. Napier, 1846-47, and was with the Sind Horse under Major John Jacob. During the Mutiny campaign in 1857-58 he served with the 2nd Regiment Light Cavalry in Rajpootana. Under Napier in 1867-68 he acted as principal medical officer of the Indian Medical Department throughout the Abyssinian campaign, for which he received the Companionship of the Bath. For his services during the Mutiny campaign he received the Indian medal and clasp for Central India. We have in type an extended obituary notice of this distinguished officer, but owing to pressure on our space we are unable to print it this week.

INDIAN ARMY REORGANISATION.

The reorganisation of the Indian Army under the Act of Parliament of 1893 has been effected. The military control hitherto exercised by the Governors in Council of Madras and Bombay is at an end, and the Indian Army is now a unified army. The Commander-in-chief in India, Sir George White, has supreme command. The Bengal Army is divided into two, that for the Punjab and Bengal, and with the armies of Madras and Bombay will form the four great commands under their respective generals and staff. The principal medical officer of the Punjab command is Surgeon-Colonel Harvey, I.M.S., and of the Bengal command Surgeon-Major-General Walsh, Army Medical Staff.

The epidemic of measles unfortunately continues to spread among the boys on board the training ship *Impregnable* at Devonport. More than fifty cases have been removed to the Royal Naval Hospital, and all newly-arrived boys are received in the gunboat *Circe*.

The transport *Warwick Castle* is daily expected to arrive at Portsmouth with nine patients for Netley from Bermuda.

Correspondence.

"Audi alteram partem."

"THE LONDON AND MANCHESTER INDUSTRIAL ASSURANCE COMPANY, LIMITED."

To the Editors of THE LANCET.

SIRS,—I have read the letters about the London and Manchester Assurance Company. I have fifty-seven patients on my list for this company, and receive £2 17*s.* on quarter day, which in a small practice is not to be despised. None of the patients I have been called to attend have been in a position to pay a bill, and if I object to any member as being of too good a social (or rather financial) position, I believe if I write to the secretary the agent is told to take them off my list. The money I receive from the London and Manchester Assurance Company, though small, is better than any other club I have had to do with—e.g., Hearts of Oak, Oddfellows, Rechabites, &c., because the money is paid regularly and the secretary is never "hard up" and asking the medical man to wait a month or two (once I had to wait fifteen months for the local secretary of a club to pay up). The average pay is also better than our provident dispensary, which has a maximum of 4*d.* a week for any family. A family of eight pays me 4*d.* In the case of the London and Manchester Assurance Company I get 8*d.* a week for the same, and the reduction from 1*s.* a quarter to 10½*d.* only takes place when I have 100 members on my list. All the medical men I have consulted who are on it seem pleased with it, and there are now 1200 qualified men engaged with the company. Should any of us resign we are bound to give three months' notice by next quarter day. I must be guided by the conduct of others as to resigning. If I feel it my duty I shall do so, though I am no doubt popular from the fact that my list nearly doubles every quarter, and in about eighteen months I shall probably draw nearly £100 a year from the company, and I can ill afford to lose the money. It is only fair to the company to say that though they pay us less than they collect, yet in many cases the people on our list cease payment at once, yet the company pay us all the same. The subject is a large one, and I have not been concise, but I should be glad to hear the views of the profession further through your columns, if possible.

I am, Sirs, yours very truly,

April 4th, 1895. C. C.

To the Editors of THE LANCET.

SIRS,—I feel sure the above subject, chosen by "A General Practitioner," is a strong one and ought to be taken up by the medical profession generally, so that it can be thoroughly ventilated and amply digested by all young practitioners. At the same time, I think if the term "Medical Aid Companies" were used instead of mentioning one, perhaps a more general conclusion will finally be arrived at. Mr. Woodward's letter is extremely amusing, especially when one glances at the figures given at the end of this letter. I question very much if the managing director has ever had the opportunity of inspecting such statistics before, although he rushes into

print to laud his company's doings, and to try to cover the system of "touting" which certainly exists in a determined way, but at the same time ridiculed by both directors and local managers alike. As my intention in this correspondence is only to give a few figures, I must not go further into this matter, but will on another occasion, if wished, go into greater detail. Being compelled through ill-health to leave town, I took a couple of years' rest, and as an opportunity cropped up for me to enter into, and carefully watch, the medical aid system, I decided to throw my whole time and energy in it. A certain sum—£100—was guaranteed to me; but before I commenced I positively refused to allow anything unprofessional to be done. Having settled thus far my duties commenced, after taking the wise precaution to obtain a surgery about a mile and a half from my house, so that I could keep a very accurate account of all proceedings. Now, if our friends will kindly look through the few following figures (which I can give in more detail if needed), they will see that when Mr. Woodward, in his letter of March 30th, talks of pecuniary assistance to the medical profession he speaks of something which he has certainly not inquired into, or otherwise his mathematics must have been grossly neglected; for the simplest rules only are needed to produce a result exactly opposite to those suggested in his letter.

The figures are given for one year, from March 25th, 1894, to March 25th, 1895, when I resigned:—

	No.	No.
Bottles to June quarter	480	—
Visits ,, ,, ...	—	131
Bottles to September quarter	568	—
Visits ,, ,, ...	—	168
Bottles to December quarter	873	—
Visits ,, ,, ...	—	441
Bottles to March quarter	579	—
Visits ,, ,, ...	—	248
Total bottles for year...	2500	—
Total visits for year	—	988

	£	s.	d.		
Cheque to June quarter	6	5	2	on 400	cards.
,, September quarter	10	19	9	,, 574	,,
,, December quarter	15	10	7	,, 696	,,
,, March quarter (but approximate)	16	0	0	,, 700	,,
Total cheque for year	48	15	6		

Now if this grand sum be divided by the number of bottles and visits I think a large fee of 3½*d.* will be the result. I now leave the pecuniary advantages—of Mr. Woodward—to the medical profession, young and old; at the same time I have a host of other information which I am prepared to communicate. I am, Sirs, yours faithfully,

April 3rd, 1895. ALEXANDER M. MOORE.

To the Editors of THE LANCET.

SIRS,—One would imagine from Mr. Woodward's letter in your issue of March 30th that in supplying medical relief to policyholders his society's only motive is to inculcate self-help in those who object to receiving charity. I think I can supply another motive. I am a medical referee to an assurance society which does a very large business among the poorer class. The local agent of this society called upon me and asked if I would allow him to "run" a medical club in conjunction with his ordinary business, for unless he could "promise them the doctor in time of illness" he could not get people to insure their lives through him, and he was utterly unable to compete against the agents of the "London and Manchester," who held out the medical club as an inducement to people to insure through them. This agent assured me that wherever he went in search of "lives" the first question was, "Can we have the doctor as well?" The medical man is thus a sop with which to procure other business. The "touts" of this society are all-powerful, and do not appear to be under any proper control from headquarters.

I am, Sirs, yours faithfully,

April 8th, 1895. BETA.

To the Editors of THE LANCET.

SIRS,—I am pleased to see the correspondence about this company. Were the members allowed entrance confined to the lower working class, and the healthy of such, there might be something in its favour even at the fee paid by the company for each. But I deny that it is confined to the lower working class. I know scores of exceptions, as I can instance. I know a man who entered who paid a medical man not much short of £30 for considerably less than twelve months attendance upon a member of his family, and he was well able to pay it as he was a considerable property owner; a schoolmistress, single, with salary about £80 a year; publicans in good trade; employers of labour; people who can employ domestic servants; people with shops doing good business; people with pianos, and who can afford music lessons for their children; clerks and well-to-do artisans, earning 30*s.* a week and over; people who come to the medical man's surgery, gloved and well-dressed, frequently without the usual bottle, often ignoring surgery hours, and expecting to be attended to or visited at any hour. Then the delicate one or ones of the family are frequently those entered. There is no medical examination. I know the company can reply that the medical man has power to reject whom he thinks unhealthy if they come early under observation, but if the rejected happen to have been private patients of his, in most instances he or she feels sore and leaves him, and the agent thinks he has a grievance because, I suppose, he loses the entrance fee. I know of people with uterine disease, hernias, ulcers, old age &c. entered. There is a proposal form with questions as to health to be filled up by the proposer. May I ask the managing director *how often the proposer fills this up himself or herself*? or if the agent fills it up, *how often he puts the questions down on it* to proposer or parents if it happens to be a child? How often the questions are seen at all by the proposer? To do the London and Manchester justice, I believe there are other companies which pay medical referees even less, but even this is a grievance, as sometimes those in the London and Manchester think they are in something "genteel" and say they are not ordinary "club patients." I can vouch for foregoing statements. I am, Sirs, yours faithfully,

April 8th, 1895. INTERESTED.

"THE WOMEN'S FREE HOSPITAL, SOUTHAMPTON."

To the Editors of THE LANCET.

SIRS,—In reply to a statement appearing in your issue of March 30th, we beg you will insert the following answer. The committee of the Women's Hospital are strongly of opinion that it would have been a more dignified course for the Medical Society to have taken if they had requested the Editors of THE LANCET to publish the whole correspondence, and not an entirely inaccurate, prejudiced, and misleading statement such as they have done, deliberately suppressing all the opinions of the Hospital Committee. To the public the verdict of the Southampton Medical Society may sound as a voice of great importance, but this attack has been conducted principally by the committee of the society, consisting of nine gentlemen, and the committee of the Women's Hospital have every reason to believe three of these gentlemen have taken no active part in the deliberations, and that of the other six, three are on the staff of another institution, including the chairman, and at least one of the answers to a request from the Hospital Committee was sent to this committee without the answer being brought before the whole society, and the resolutions were passed by a body of twenty-seven gentlemen out of a society of fifty members. It may be of interest in weighing the importance of the deliberations of the Southampton Medical Society for it to be known that at least three prominent members of the profession (one a gentleman who has been present at a large number of the operations performed, one who from actual experience knows how the work is carried on) have resigned their membership of the Southampton Medical Society, as they entirely disapprove of and disagree with the action some members of the society have taken. After a few explanatory remarks, the committee wish to tabulate the allegations, insinuations, or charges (it is rather difficult quite to know which is the correct word), which with much difficulty they have abstracted from the rambling compositions of Mr. Bullar and the printed statement of the Medical Society; then to answer these statements one by one; and finally to bring a few prominent facts clearly before the medical profession. To save repetition we enclose you the whole of the correspondence, and we will only refer to each letter, which references you will doubtless verify.

It has been reported to several members of the committee that patients who have attended the hospital have been

sought out and catechised as to the opinion &c. that were given them, and that in some cases "*evidence*" has been committed to writing. Such reports naturally shake the confidence of the committee as to the unprejudiced nature of the attack that has been made, although the committee were loth to believe that any member of the Southampton Medical Society could have adopted such a reprehensible method, seeing how well it is known that great care must always be exercised in accepting any statements made by patients—especially women—about one medical man or hospital to another practitioner or institution. The committee hoped these reports would have been contradicted by the Medical Society answering these questions as to "when" and "by whom" the evidence was obtained that warranted the society in making the accusation it has done. A large bulk of the statements of the Medical Society can easily be disposed of, as the committee have already expressed their view on friendly criticism as opposed to hostile attacks (Letter 2, p. 6), and on questions of management as well as on questions of finance (see Letter 2, p. 7), which they are of opinion are matters concerning the subscribers, and not Mr. Bullar. As far as the committee are able to discover, the charges which Mr. Bullar has tried to make are—(1) against the constitution, work, and management of the hospital; (2) that the hospital is not free; (3) that the medical officer reported on the nursing staff; (4) that the secretary has not access to the books; (5) that the question of finance is not sufficiently explicit in the reports; (6) that operations are recklessly and unjustifiably performed, and results are not sufficiently reported; (7) that the staff is deficient; (8) that the committee have not proper control; (9) there are no rules; (10) that five operations have been done without proper consultation; (11) that the committee refused a committee of inquiry; (12) that Dr. Playfair supported the view; (13) that Dr. Playfair has resigned; (14) that Mr. Eliot has no special knowledge of the diseases peculiar to women; (15) that operations have been advised, not performed, and the patients are now alive and well.

1. As regards "constitution," the committee have answered. (Letter 2, p. 6.) As regards "work" this will be referred to again. As regards "management," again we refer to Letter 2, p. 5. The committee clearly stated that they thought it incredible that a professional man should endeavour to prejudice an existing institution by bringing forward questions of this kind, which can have no bearing whatever upon the present work of the hospital or its utility as a public institution. The committee have pointed out in their report that the hospital has laboured under many disadvantages during the past—the death of a lady who took an active part in starting the hospital, and the loss of the chairman of the committee, the Right Rev. Bishop Perrin, who left Southampton when he was created Bishop of Columbia. All this was known to the Medical Society, who seized on this opportunity to attack the institution. 2. The statements made by the Medical Society are not true. No hospital patient *has* to pay £2 2*s.* a week, and the arrangements made for defraying the expense of in-patients is a matter which concerns the subscribers, and not Mr. Bullar or the Southampton Medical Society. The actual arrangements are as follows:—Originally the out- and in-patients were treated in the same building—which arrangement ceased upon the advice of the medical staff, as they found it was inadvisable to perform serious operations in a building to which out-patients came, and in consequence arranged (as a temporary measure, until they could build permanent premises) with their medical officer to receive their two beds in a ward in his private hospital for the *exclusive* use of hospital patients. The same kind of arrangement was employed by the founders of the Hospital for Women at Birmingham many years ago, where it was found that the presence of out-patients in a building where serious operations are performed is seriously prejudicial to the latter. In the majority of cases patients have been treated without payment of any kind, but on account of the low state of the funds of the hospital some patients have been asked if they could afford to pay a small sum towards the out-of-pocket expenses, and this they have gladly done, from sums varying from 5*s.* a week up to, but never exceeding, £2 2*s.* a week, only four ever having paid this latter amount. No patient has ever been refused treatment on account of inability to contribute towards her expenses, and as it has been insinuated by the Medical Society that their medical officer might have derived some pecuniary benefit by this arrangement the committee are glad of this opportunity of giving a most emphatic denial to this most unworthy conclusion. 3 Refer to Letter 2, p. 7. This was fully answered and the committee considered Mr. Bullar's remark as impertinent. The medical officer will continue to report from time to time, to the committee, on such matters of so great importance as that of nursing. One great reason for giving this report was that through the kindness of Mr. Lawson Tait one of his most experienced nurses resided here for some months, in order to teach some of the nursing staff who nursed hospital in-patients Mr. Tait's *special details in nursing abdominal section*. Reports regarding nursing are regularly included in the Medical Board's annual report at the Birmingham Women's Hospital. 4. This at first sight appears an error of management. The reply of the secretary of the Southampton Women's Hospital intended politely to convey to Mr. Bullar the fact that the books were inaccessible to the hon. secretary for the purpose of giving information and statistics to any person who chose to ask for these for the purpose of formulating attempts to damage the institution. 5 This the committee have referred to, and decline to receive interference on the point from the Southampton Medical Society, as being one purely of finance and affecting themselves and their subscribers alone. The accounts we published in the printed reports of the hospital, which are in your possession. 6. This the committee consider the pith of the whole attack, and, in order to raise a definite issue, the committee will confine themselves to dealing with the 24 cases referred to by Mr Bullar.

Nineteen out of the 24 cases were seen by Mr. Lawson Tait, and operation proved in each case the diagnosis was correct. This leaves a balance of five cases. These latter operations were as follows: (1) pyo-salpinx (successful, with recovery); (2) suppurating hæmatocele (intra-peritoneal, urgent); (3) cystic ovaritis (intra-peritoneal, urgent); (4) chronic salpingitis and ovaritis (intra-peritoneal, urgent); (5) pyo-salpinx (intra-peritoneal, urgent). Ample assistance was always procured; as a matter of fact, a member of the Southampton Medical Society itself was present in four of the five cases and thoroughly approved of everything that was done, and the committee have been personally assured of this by the member himself, and the specimens in Mr. Eliot's possession amply prove the wisdom and propriety of operating in these cases. It may be well here to state that, although this charge was never absolutely definitely framed, it was hinted at both in print and by various members of the society to their various patients, and has been used as a weapon and (what the Medical Society has considered) a powerful argument against the hospital. Knowing this, Mr. Lawson Tait and Mr. Eliot thought it would be the fairest way to read a paper on all the cases which had been operated on, and Mr. Lawson Tait wrote and made this offer to the Southampton Medical Society, but apparently the society was loth to hear the truth, and preferred to continue to cast innuendoes "about what they knew," as they treated the offer with absolute and most discourteous silence, never even acknowledging to the committee the receipt of Mr. Tait's letter. The committee do not think they need refer any further to this matter. All this was clearly stated in the correspondence, but suppressed by the Southampton Medical Society. It may be also well to add that all professional information asked for by the Southampton Medical Society was immediately given. (See tables at end of Letter 2.). The statistics were copied from the books, and the only cause of complaint could but be that they had not been properly published. In the report that was next published the committee gave additional information on the subject of the operations—more information than is to be gleaned from the published reports of any other institution in the town—and in the face of this the Medical Society have seen fit to use this complaint as a weapon against the hospital in their statement published in THE LANCET. The committee, in Letter 2, pp. 6 and 7, express their views about ratios as to number of operations, and to avoid repetition they beg to refer you to such letter. The committee cannot deal with ratios, but with facts and individual cases. The committee venture to think that you will agree with them that it is not fair to compare a hospital like the Chelsea Hospital for Women, dealing with an enormous number of cases, to a small hospital in a provincial town carried on for a special purpose, to which naturally only a comparatively small number would go. 7. It may be so in the opinion of the Southampton Medical Society, but it is the

opinion of the committee that it is "sufficient" and "efficient." We refer in connexion with this statement to Mr. Lawson Tait's letter, bearing date Oct. 22nd, 1894, published in THE LANCET, explaining the reason for the constitution of the staff of which the Medical Society complained. 8. The committee beg to state they have absolute control. 9. The rules which have been made from time to time have been drawn up, and are printed in the last report. Notwithstanding their knowledge of this, the Southampton Medical Society make complaint of it in THE LANCET. 10. This is so. As referring to the 24 operations, it is stated that Mr. Lawson Tait saw 19 of the cases. Of the other 5 cases above referred to, 2 were cases of emergency (Cases 2 and 5); 1 Mr. Lawson Tait was prevented from being present at (Case 4) owing to illness, and the other 2 were cases demanding operation. In each of these cases, as before stated, the most efficient and able assistance was procured, and the committee are satisfied that every care and precaution has been taken, and there is absolutely no cause for complaint. 11. This seems a serious offence in the eyes of the Medical Society, but the committee of the Women's Hospital have been unable to come to the conclusion that the attack made upon them by the Medical Society is of a genuine and public-spirited character, and they therefore took the view—and still strongly maintain it—that they would not listen to the proposal for a committee of inquiry until they, as the responsible body, had been informed *clearly and definitely*, not as mere vague insinuation, what the charges were which they were called upon to answer. The committee think that had they been acquainted with detailed charges *and failed to investigate them satisfactorily*, then the Southampton Medical Society might have thought they had a ground on which to base their suggestion. The committee offered to investigate any such charges *and to fully acquaint the Medical Society with the action they had taken in the matter*. The committee did refuse the proposal, and see no reason to alter their opinion; but it must not be thought from this that the committee of the Women's Hospital ever had any desire to avoid publicity. The Southampton Medical Society held out as an inducement to the committee to accede to their request "that further publicity would thus be avoided." To this somewhat extraordinary proposal the committee replied: "And we refuse to join with the Medical Society in any arrangements which would have the effect of concealing anything which, in the public interest or in the interest of medical science, should be known." We trust, however, from the full information that we have afforded, you will readily see that the committee have nothing whatever to conceal, and you are quite at liberty to publish the whole of the correspondence that has passed, and they would be only too ready to consider and accept *bonâ-fide* suggestions for the improvement of their institution. 12. The committee exceedingly regret having publicly to express their views on this point, but it is necessary to do so. They are of opinion that Dr. Playfair has treated them in a most discourteous manner. He listened to the accusations of the Medical Society. He never communicated with the committee or the staff of the hospital to which his name was attached, and the committee of the Women's Hospital received a letter from the *Secretary of the Medical Society*, to whom Dr. Playfair had written, saying he strongly approved of the proposal of the Medical Society as to holding a committee of inquiry. Dr. Playfair, *without being fully informed of the facts*, expressed his opinion, agreeing with the Medical Society, and therefore the committee of the Women's Hospital did not see the necessity of taking Dr. Playfair's advice into consideration. The committee are of opinion that Dr. Playfair should have resigned before throwing in his lot with the party adverse to the interest of the hospital, or declined to have given an opinion until he had received the view of the Hospital Committee. 13. Dr. Playfair has resigned under the circumstances stated above, and under the circumstances the committee see no reason to regret the course he has taken. 14. The committee very much regret that they are called upon to defend the reputation of one of their medical officers. The committee prefer to take the opinion of those gentlemen who know Mr. Eliot and know from actual experience and observation what his capabilities in this particular branch of practice are. And, apart from these opinions, the fact that Mr. Eliot has for some years past worked with Mr. Lawson Tait (witnessing Mr. Tait's operations, and operating himself under Mr. Tait's immediate observation) is quite sufficient to warrant the committee of the hospital in again endorsing the statement referred to in THE LANCET by the Medical Society, and they are quite conscious of the fact that the success that has attended the work under their control is in a large measure due to the fact that Mr. Eliot has been and is always availing himself of every opportunity to acquire a knowledge of the most modern methods of treatment in this particular branch of practice, and the view the committee hold is fully borne out by the statement contained in Mr. Tait's letter. 15. It is almost incredible that a body of gentlemen could publish such a statement. In no one single instance have the Medical Society asked for information, but seem quite ready to rely on the bare statement of a hospital outpatient. The committee are quite content to leave criticism of this statement in the hands of the public, and especially those of the public who are acquainted with hospital outpatients. They strongly condemn the action of the society in publishing such a paltry accusation without making any effort to verify the statement in one single instance. It savours of the lack of candour and of the prejudice and narrow mind which have characterised the whole of this action.

It now only remains to prominently call attention to a few facts: (*a*) If the attack of the Medical Society was unprejudiced and promoted in the public interest, it is most extraordinary that every point in favour of the hospital has been deliberately suppressed in the statements sent to THE LANCET. (*b*) That the Medical Society has avoided and shirked in every possible way every offer from the committee of the Women's Hospital which would have enabled them to have arrived at the real facts of the case. *They would not hear a statement from Mr. Tait and Mr. Eliot on all the operations performed*, still maintaining (or insinuating) that operations were recklessly performed. They would not state any single case in support of these many accusations, although they have been repeatedly urged to do so by the Hospital Committee. (*c*) That gentlemen who are senior in the profession, and whose opinions are most valuable, have in consequence resigned their membership of the Southampton Medical Society. (*d*) The committee have only one object in view, and that is in a particular branch of science to bring the highest possible advantages of modern art and surgery within the reach of some of the poorer women in this town. (*e*) That in no other institution in the neighbourhood could a patient receive the advice of a surgeon of Mr. Tait's special experience.

In conclusion, and reviewing the whole correspondence and actions of the Medical Society, the committee cannot help drawing attention to the opening remarks of Mr. Bullar's first address, in which he carefully defines "professional jealousy" in its "good form" and its "bad form." The committee cannot discover the former—they sincerely hope it is not the latter.

(Signed)
A. F. FORBES, M.A.,
Chairman of the Committee.
H. C. PHILLIPS, Hon. Sec.,
Southampton Women's Hospital.

April 6th, 1895.

*** We have received with the above letter copies of all the documents referred to therein. We cannot assume the position of arbitrator, but it seems to us that both indictment and answer might well have been shorter and more specific and categorical in character.—ED. L.

"SATISFYING (OR NOT) THE EXAMINERS."

To the Editors of THE LANCET.

SIRS,—May I be permitted through your columns to ask the following question? Why is such mystery practised in the results of the examinations of the Royal Colleges of Physicians and Surgeons of England? To illustrate this, a medical student competes for an examination. He fails, and has not the satisfaction of knowing whether his failure is due to the written or oral part of his examination. The information he obtains is, "he has not satisfied the examiners." If such a system as the publication of the marks he had obtained in the several parts of the examination was observed I think the dissatisfaction which now exists would be at an end. Although a candidate is voiceless in the matter, still the Colleges of Physicians and Surgeons would, I should imagine, in reason concede to any system which would tend to advance the welfare of medical students.

I am, Sirs, yours faithfully,
C. TILBURY FOX.

University College Hospital, April, 1895.

"THE TITLE OF 'DOCTOR.'"

To the Editors of THE LANCET.

SIRS,—In your impression of the 30th ult. "M.R.C.S. &c." states with reference to my previous communication on this subject: "Whilst entirely agreeing with him [the writer] that assuming the title of 'Doctor' without a degree entitling one to it should be considered infamous conduct 'in a professional respect,' I cannot agree with him as to the deception practised on the public." If "M.R.C.S. &c," then, agrees with me that no medical practitioner should be allowed to assume the title of "Doctor" "without a degree entitling one to it," how can he reconcile this first position with the subsequent sentence in his letter? "Let all 'M.D.'s' be called physicians, and ordinary diplomates 'Doctors'; for, whatever our qualification is, *we are* 'doctors.' Why should we not be allowed to say so?" Why should not the licentiates be allowed to do what he holds to be "infamous conduct in a professional respect"? The fact is that many of them do so, and do it without challenge from either the General Medical Council or the bodies from which they hold their qualifications. The "deception practised on the public" is to my mind quite clear. When a man practising medicine, surgery, or any of their collateral departments—such as dentistry, &c.—prefixes his name with the style "Dr.," he certainly leads the public to infer that he is in possession of the degree of "doctor of medicine," and *whether intended to deceive or not*, if the public are naturally led to misapprehend the act is legally construed as criminal. The whole crux of the question lies between an academic distinction and a vulgar appellation. It is the former and not the latter that a gentleman is expected to put on his door-plate or visiting card. I have never instituted an irrelevant comparison between "licentiates" and "doctors" in respect of medical or general culture. This is a matter entirely outside the argument. I do not regard the mere possession of the doctorate degree as any guarantee of either medical or general acquirements, as I know hosts of "doctors" who are as capable of reading Hebrew as they are of translating their diplomas; but if the "licentiates" consider themselves equal in culture and general acquirements to the "doctors," why do they assume a title which they do not possess? Mr. Pike, in the same number of THE LANCET, says that he has repeatedly applied to the Edinburgh College of Physicians for guidance on this matter, and that he has always received the reply that "my legal title as 'licentiate' was that of physician." Then why does he use any other than his "legal title," even if the College of Physicians is weak-kneed enough to connive at his professional use of a distinction to which on his own showing he has no legal claim?

I am, Sirs, yours faithfully,

Glasgow, April 7th, 1895. D. CAMPBELL BLACK.

To the Editors of THE LANCET.

SIRS,—I fancy that Mr. A. de W. Baker is not well informed on the state of practice in general if he imagines that matters will "tell seriously against the London corporation and schools" unless some device is found for conferring the title of "Doctor." As a matter of fact, I happen to practise in a degenerated London suburb where medical men, not being graduates, one after the other, without the slightest ceremony, confer the title upon themselves, and this in a far more ostentatious fashion than the respective universities would probably care to have their own legitimate titles displayed. Indeed, one gentleman, who resided in the neighbourhood in its palmy and refined times, and who might in vulgar and popular estimation be considered the leading practitioner, I believe, did so from the first. No doubt it may be conceded that on the whole the title is so diversified that it confers more of a social than intellectual distinction. Be this, however, as it may, it is obviously absurd for practitioners, not being graduates, to advance individual claims on purely intellectual lines to a title they do not possess.

I am, Sirs, yours truly,

London, April 9th, 1895. M.R.C.S.

DISINFECTION OF SCARLET FEVER.

To the Editors of THE LANCET.

SIRS,—Dr. Priestley's paper, an abstract of which appeared in THE LANCET of April 6th, is a valuable contribution towards elucidating the advantageous results obtained by the inunction of scarlet fever cases with the oleusaban eucalyptus oil. His results, obtained from 120 cases treated in the Leicester Fever Hospital, confirm my statements that albuminuria rarely occurred (his cases were as 1 to 10 of those treated in the ordinary way); that desquamation was hastened (his cases were discharged from hospital a week earlier than the others, saving 14*s.* a case, or £84 on the 120 cases); that there were few or no deaths (his deaths were 1·6 per cent. to 4·3 per cent. in those under other treatment). The cases with suppurative complications were about the same. These, I maintain, are chiefly due to hospital infection by the streptococcus pyogenes, as we get few or none of these cases in private practice whether treated by eucalyptus or not, and therefore this must be taken into consideration when estimating the results of the eucalyptus treatment. I have before stated that in 156 cases treated in their own homes at Bexley there were no suppurative complications; and I think that Dr. Little of Wimbledon stated at the discussion of Dr. Priestley's paper that he had none there, and most of his eucalyptus-treated cases were discharged from hospital at four weeks and all before the fifth week.

Dr. Priestley says that "it would be manifestly unfair to include cases with only initial symptoms—e.g., sickness, headache, and sore-throat," in the treatment. But these are the cases on which the antiseptic treatment has most effect in checking the fever and sequelæ. Used thus early during the initial symptoms the poison is destroyed, or it is deprived of much of its power for mischief. If the inunction is delayed until the rash is fully out the poison has produced those changes in the epithelium and the tissues which lead to complications. The pseudo-scarlatinal cases, where the evidence of infection is confined to the throat, with, in some cases, a slight rash behind the ears for a few hours, are capable of infecting others, as I have witnessed, and should be treated antiseptically. Cases of scarlet fever occur without any rash being observed, as well as small-pox without pustules, or with only two or three, and if it is desired to stop the spread of infection no mild case of this description should be neglected.

The questions to be decided by those who are investigating the treatment by eucalyptus inunction are: 1. Does it check or stop infection? 2. Does it lessen or shorten the fever? 3. Does it shorten the period of desquamation? 4. Does it prevent albuminuria? 5. Does it reduce the number of deaths? I, as well as many others, say it does all this, and it is for its opponents to prove by adequate experience that it does not. The first question is best tested by treating the cases at their own homes without isolation, as I have done, and allowed other children to enter the patient's room unrestricted after he has been inuncted and the air of the room well saturated with the vapour of the oil.

I am, Sirs, yours faithfully,

Teddington, April 8th, 1895. J. BRENDON CURGENVEN.

"THE NORMAL PRÆCORDIA IN CHILDHOOD."

To the Editors of THE LANCET.

SIRS,—With reference to the annotation on this subject in your last issue giving the results of Dr. Whitney's observations on the limits of the (superficial) cardiac dulness in children at various ages, I would point out that his conclusions are altogether at variance with the observations of Stärck on 300 healthy children, quoted in your columns by the late Dr. Sturges.[1] Dr. Whitney's principal conclusion is that after the age of seven or eight years the area of dulness becomes enlarged, the upper border rising often to the second left interspace, and the apex beat, originally within the nipple line, falling to its outside. Stärck found, on the other hand, that the area diminished with the child's age, falling between the sixth and twelfth years by the width of a rib, and that the apex beat, which was at first outside the nipple line, became internal to it after the age of six years. Dr. Garrod[2] has made some tracings of the area of dulness in children, which generally accord with Stärck's conclusions. It is curious that statements so diametrically opposite in their tenour should be put forward by apparently careful observers. As the dimensions of the superficial cardiac dulness depend mainly upon the extent to which the organ is overlapped by the edges of the lungs, it is of essential

[1] THE LANCET, vol. i. 1894, p. 653.
[2] Brit. Med. Jour., vol. i. 1894, p. 561.

importance that in all instances noted, not only should the heart itself be healthy, but the lungs also should be healthy and of good development and the thorax of normal shape. Inattention to these points may account for some of the discrepancy. In one of Dr. Garrod's cases "physiological albuminuria" was stated to be present; the heart is not generally, in my experience, normal in the subjects of that condition. Dr. Peacock[3] has pointed out the influence of full expansion of the lungs, as in those who lead lives of active exertion, in altering the position of the heart. The organ sinks in the chest under these conditions, but it rises, and is small and shallow, in those with weak and ill-developed lungs. It is true that this would apply less in the case of children, yet here also there is much variation in the functional activity of the lungs. Further, in children the existence of the thymus glands furnishes a disturbing element; its gradual atrophy (vanishing at puberty) should allow the edges of the lungs to approach nearer to one another and so diminish the area of cardiac dulness, agreeing thus with Stärck's view. I am inclined to think that, when we take all these circumstances into account, we must admit that there is great variability in the extent of this area in healthy children. As to the site of the apex beat of the heart in childhood, my own limited observation has shown that this is found in very young children to be in or outside the mammary line, and that it travels inward during later childhood to take up the position natural to adult life. This accords with the statements of Stärck and not with those of Dr. Whitney.

I am, Sirs, yours truly,

Finsbury-square, E.C., April 8th, 1895. R. HINGSTON FOX.

THE PRESENT POSITION OF THE OBSTETRICAL SOCIETY OF LONDON.

To the Editors of THE LANCET.

SIRS,—This society was instituted for the promotion of knowledge in all that relates to obstetrics and the diseases of women and children. The laws regulating its affairs were, therefore, drawn up for a scientific society. At the present time the council has launched upon a career of political agitation, acting as the deputy of the Midwives Institute and the Society for the Promotion of Registration for Midwives. As a result, the name of the society and such prestige as it possesses, are being used to foster legislation to which there are very grave objections, and which has not been submitted to the Fellows for their approval. The President, who stated to the House of Commons Committee that "if he was a poor woman he should prefer to be attended by a really well-trained midwife than an overworked doctor," and the Chairman of the Midwives Board, who has publicly stated "that, from his own experience of the enthusiasm that women, as a rule, brought to bear upon the training, a candidate at the end of three months' training would be able to put to shame in a midwifery examination an ordinary medical student of three years' training," are fair examples of the school of thought represented by the large majority on the Council. With such very poor ideas of the knowledge and capacity of the men for whose teaching and training they and their class are responsible it cannot be a matter of astonishment that the rules of the society have been strained to breaking point for the promotion of legislation intended to facilitate the removal of the practice of midwives from the hands of the medical profession, and in fact to place it on the Continental basis.

The question now arises—Is it the wish of the Fellows that the society should be used as a means to further this end? The rules of the society admit of no discussion on the subject except at the annual meeting held in February, and the Council brought forward nothing at this year's meeting of a contentious nature. At the annual meeting every Fellow is summoned by letter, a week's notice being given, and it is quite clear that the business brought forward by the President in his address should have been brought forward by the council on that day. However, stealing a march on those who are opposed to his views on midwives' registration, he takes the field when he is absolute master of the situation. At ordinary meetings of the society and at meetings of the Council he is the sole authority, and although it is quite clear from a perusal of the laws that it was never contemplated that the President would introduce contentious business into his address, and take up the position of a partisan in a matter of politics, yet he does both, and allowed Dr. Griffith to propose a resolution of an important character at the ordinary meeting in March, in defiance of the spirit of the rules. At the next ordinary meeting, when, after the reading of the minutes, I attempted to call attention to this resolution, the President prevented my doing so, on the ground that my action was against the laws of the society. Now I am informed officially that the only means of testing the feelings of the society upon the important question of its approval of the introduction into the sphere of the society's activity of political questions, and of the action of the President and the council, is by representations to be made to the council by three Fellows that they desire the repeal or alteration of some laws, and it has been suggested to me that the best course to pursue is to send an appeal to the council signed by as many Fellows as possible to summon a special meeting to consider the propriety of the repeal of Chapter XV. of the Laws, which relates to the Board for the Examination of Midwives. Sitting on the council, as I do, I have objected absolutely to the course pursued, because the members of the council were not elected this year by their constituents with any mandate to alter in any way the character and objects of the society, which have always been scientific in character. Moreover, the laws of the society do not admit of any practical check being placed on the action of the council; it is elected upon general and scientific grounds and not upon political basis at all. Under these circumstances I shall be glad to receive as many names of Fellows as possible, and as soon as possible, who desire the repeal of Chapter XV. of the Laws to be considered by the society.

I am, Sirs, your obedient servant,

Hatfield, Herts, April 8th, 1895. LOVELL DRAGE.

[3] Reynolds's System of Medicine, vol. iv., pp. 65, 86.

LIVERPOOL.

(FROM OUR OWN CORRESPONDENT.)

The Recent Murder of an old Man and Attempted Murder of a Boy.

THE inquest on the body of the old man Edward Moyse was resumed and concluded by the city coroner, Mr. T. E. Sampson, yesterday. The case was alluded to in a recent letter. It caused much excitement at the time, in consequence of the critical state of the principal witness and of the circumstance that the perpetrator of the crime was not known. A man has, however, since been arrested by the police, and the coroner's jury yesterday returned against him a verdict of "Wilful murder." The evidence of Mr. Paul showed that the deceased had in all probability been stunned by a blow on the face and killed by subsequent blows with a hatchet or some similar weapon. Dr. Musson, one of the resident medical officers of the Northern Hospital, stated that the boy Needham, when admitted into that institution at an early hour on Feb. 19th, was suffering from shock and loss of blood, and was in a terrified condition when anyone touched him. He had fifteen cuts on the head, six of which extended to the bone, and in three places the skull was fractured. He had also two cuts on the back of the right hand and the left hand was bruised; the upper lip was cut and the right shoulder slightly bruised. The operation of trephining was performed, and the boy recovered sufficiently to be able to identify his assailant. He also gave evidence at the inquest and identified the prisoner (Miller), who was present, as the man who had assaulted him.

Coroners' Inquests and Medical Evidence.

Referring to the leading article in THE LANCET of last week on coroners' inquests, it may be repeated here what has been stated before, that the present city coroner avails himself in all important cases of expert evidence, at the same time the rights of the practitioner first called to the case are always scrupulously respected. In Liverpool the practice used to be to send for the nearest medical practitioner in cases of accident or urgency. Now the hospital ambulance has largely supplanted those gentlemen who would formerly have been called upon to attend such cases, these being now attended by the ambulance surgeon in the first instance and the resident staff afterwards. The present city coroner has expressed regret that the law does not permit him to remunerate medical practitioners for such

assistance as they may be able to give him in cases where he does not consider it necessary to hold an inquest. If he possessed such power it might reduce materially the number of inquests.

April 9th.

SCOTLAND.

(FROM OUR OWN CORRESPONDENTS.)

Presentation to Professor Sir William Turner.

LAST week the veteran Professor of Anatomy in Edinburgh University was presented with his portrait in recognition of his services to anatomy and to the University of Edinburgh. The presentation was made in the large theatre in presence of a large number of friends and admirers. Sir James Russell presided. Professor Cunningham, who had acted as secretary to the presentation committee, intimated a large number of apologies and regrets for absence. Sir James Russell, in making the presentation, referred to the valuable services rendered to science by Sir William Turner's work, and also spoke of his invaluable services to the University as an administrator. Many were tied to him personally because of what he had done for them, for the lessons of untiring industry, indomitable perseverance, and clearness of order and method which he had taught them. Sir William Turner, in acknowledging the gift, referred to the time, twenty-eight years ago, when he was appointed to the chair in succession to John Goodsir. In 1854 he had been appointed a demonstrator under Goodsir, and he considered it fortunate that he had been early brought under the influence of a man of such marked personality, vigorous intellect, and so original in his conceptions. He referred to the changes brought about in the University by the Universities Commission, but expressed his unbounded confidence in the Scottish University system. He referred to the work he had had to do as an administrator in the University and said that he thought teaching anatomy was one of the best preparations for a business life, because it tended to make one methodical and orderly in the arrangement of facts and clear and precise in expression. Sir William Muir proposed the vote of thanks to Sir James Russell. The portrait is by Sir George Reid, P.R.S.A., and is acknowledged on all hands to be one of the artist's most successful efforts.

The McEwan Hall.

The McEwan Hall at the new buildings of the Edinburgh University is rapidly approaching completion, and it has been intimated that Mr. McEwan is to make arrangements with the University Court by which the hall may be used by the Lord Provost and magistrates for important civic functions. The hall will accommodate 3000 persons.

Health of Edinburgh.

The epidemic of influenza has practically passed in Edinburgh. Measles is still epidemic, there having been 239 intimations of fresh cases last week; there were also 7 fresh cases of small-pox and 1 death.

Perth.

During the same week the number of deaths at Perth was only 11, showing a mortality rate per 1000 of 18·9. This is the lowest mortality recorded for the week in the eight principal towns in Scotland, the highest being that of Aberdeen, 30·3. One case of diphtheria was registered at Perth and one at Edinburgh, the only towns where this disease made its appearance during the period under mention.

Aberdeen University Buildings Extension.

On account of the contributions coming in so slowly it has been found impossible meantime to carry out the building extension scheme at Marischal College in its entirety. It has accordingly been resolved to drop for the present the proposed block in front. The south and north wings will be finished by towers according to a modified scheme which will require £16,000 to complete. If £10,000 of this be raised otherwise, Mr. Charles Mitchell, LL.D., of Jesmond Towers, Newcastle, will add to his previous generosity by a gift of the balance of £6000, besides £1000 for a clock for the Mitchell Tower. The modified scheme will permit of the natural philosophy classes being, as arranged, located at Marischal College for the benefit of the medical students. It also provides for the widening of Broad-street from Longacre to Littlejohn-street and the removal of the Greyfriars Church from its present site. The result will be the throwing open to uninterrupted public view of the quadrangle, including the fine polished granite obelisk in memory of Sir James McGrigor—so long connected with the Army Medical Department—and the handsome buildings surrounding the quadrangle, while the new Mitchell Tower will crown the background in an imposing manner. A tender has been accepted for the new electric organ for the Mitchell Graduation Hall, the cost being 1000 guineas. Among additional subscriptions from India just received by the hon. treasurers of the buildings extension scheme may be mentioned: Surgeon-Colonel R. Harvey, £100; Brigade-Surgeon-Lieutenant-Colonel G. A. Maconachie, Malabar Hill, 100 rupees; Dr. G. Watt, C.I.E., 100 rupees; Surgeon-Lieutenant-Colonel R. L. Dutt, 50 rupees; Surgeon-Major S. H. Dantra, 100 rupees; Surgeon-Captain D. M. Davidson, Gurdaspore, 50 rupees; Surgeon-Captain A. Alcock, 100 rupees; and Surgeon-Captain J. Murray, 100 rupees. His Excellency the Viceroy gives 200 rupees, and there are various subscribers in the Civil Service, besides civil engineers and clergymen.

Sad Death of a Young Physician.

It appears that Mr. John Pye Farquharson, M.B., C.M. Aberd., assistant to Dr. Mitchell, New Deer, had been in the habit of reading in bed by candle-light. About three o'clock on the morning of Wednesday, the 3rd inst., Dr. Mitchell, who slept in the room below, was aroused by a moaning sound coming from Dr. Farquharson's room, and proceeding thither found the room full of smoke, the bedclothes smouldering, and its occupant in an unconscious state. Though Dr. Farquharson had no recollection of how it came about, it is clear that he had fallen asleep and by some movement brought the bedclothes in contact with the light. Dr. Farquharson, who was very severely burned, died on the 6th inst. from the effects of his injuries. He was the elder son of Mr. P. Farquharson, a member of the Aberdeen Town Council, and graduated M.B., C.M., at the University of Aberdeen in 1891, and was for a time resident medical officer of Ardwick Provident Dispensary, Manchester. He was well known while a student at Aberdeen as a player of Rugby football, and was exceedingly popular with his classfellows.

Vaccination in Scotland

In the annual report of the Registrar-General for Scotland for 1894 there are contained the statistics of vaccination relating to the children born during 1893. These show that of 127,155 children born in Scotland, 108,117 or 85·028 per cent., were successfully vaccinated. In 2474 cases certificates were granted by medical officers, being at the rate of 1·946 per cent. of the whole births; in 509 cases the children were certified to be insusceptible of vaccination in consequence of some constitutional peculiarity, being at the rate of 0·4 per cent.; 273 children, or 0·215 per cent., were insusceptible from having been vaccinated, but by persons who were not qualified to grant certificates to that effect; and one child was insusceptible from having had small-pox; 12,781 children, or 10·051 per cent. of the whole births, died before vaccination; and 3000 children, or 2·359 per cent., were removed from the district in which they were born before vaccination, or in some other way unaccounted for. It is noted that the proportion of children constitutionally insusceptible and of those who died before vaccination were considerably above the average for the preceding ten years. Further statistics are given showing that of the 114,374 children alive at the age of six months, 108,117, or 94·524 per cent., were successfully vaccinated. These figures are fairly concordant with those of England and Wales, the proportion of the successfully vaccinated being, however, somewhat higher in Scotland. Appended to the statement as to vaccination is an instructive return of the small-pox mortality in Scotland since 1855, including a table showing the ages at death during several periods, the percentages being as follows:—*At ages 0 to 5:* 1894, 16·81 per cent.; 1885–94, 14·52 per cent.; 1875–84, 20·19 per cent.; 1865–74, 28·41 per cent.; 1855–64, 75·03 per cent. *At ages 5 to 20:* 1894, 10·62 per cent.; 1885–94, 10·75 per cent.; 1875–84, 25·96 per cent.; 1865–74, 28·96 per cent.; 1855–64, 12·19 per cent. *At ages 20 to 60:* 1894, 66·37 per cent.; 1885–94, 69·89 per cent.; 1875–84, 52·89 per cent.; 1865–74, 41·54 per cent.; 1855–64, 12·67 per cent. *At 60 and above:* 1894, 6·2 per cent.; 1885–94, 4·84 per cent.; 1875–84, 0·96 per cent.; 1865–75, 1·09 per cent.; 1855–64, 0·11 per cent. The returns for 1894 are not completed; they comprise only

113 deaths in eight principal towns, but the figures are interesting as showing the notable change in age-incidence of the small-pox deaths in that of the three decades subsequent to the Vaccination Act coming into operation, compared with that of the ten years preceding this (in 1855–64). It will be seen that the relative mortality has shifted from the earlier to the later periods of life in a striking manner.

Caithness County Council is to erect a hospital (twelve beds) in the town of Thurso. As hospital accommodation for rural districts in the county it is proposed to rent suitable houses.

April 9th.

IRELAND.

(FROM OUR OWN CORRESPONDENTS.)

Down District Asylum.

I FIND from the report of the resident medical superintendent, Mr. Nolan, for 1894 that during the year there were 623 cases under treatment. There were 72 discharges and 50 deaths, and there was an excess of 2 males and 79 females over the normal limit of accommodation. The unusually high number of admissions (159), higher than any other since the opening of the asylum in 1869, may be taken not as indicating a proportionate increase of insanity in the county, but as due to the extension of more enlightened views regarding the nature and treatment, rather than as a rapid growth of insanity. There was a history of heredity in 33·3 per cent., but, owing to the very imperfect family histories obtained from the class from whom the patients are drawn, and their natural reticence to give information on such a subject, it may be safely assumed that this percentage is very much under the real number. As asylums are now much more appreciated than formerly it is, although a paradox, a fact, as Mr. Nolan states, that the wiser we grow the more insane will be found in our asylums.

Belfast City and District Lunatic Asylum.

At the monthly meeting of governors, held on April 8th, the resident medical superintendent stated that there were at present in the house 231 males and 137 females over the normal accommodation. The proposed alterations at Purdysburn, when completed, will afford accommodation for 75 male patients, but will give no accommodation for female patients, and, as the County Antrim Asylum will not be ready for at least twelve to eighteen months to come, additional accommodation, even for chronic patients at Purdysburn, would be urgently needed. It was decided to discuss the whole matter of providing for this increase of patients at the next meeting.

The Purdysburn Sewage Scheme.

A very large and important deputation of people in the district of Purdysburn appeared before the Board of Governors on April 8th, to protest against the proposal to carry any of the sewage into the local river. After the deputation had been heard Alderman Graham, M.D. (one of the Governors), who is chairman of the Public Health Committee of the City Council, said he had always disagreed with this sewage scheme, as he condemned all systems, such as the one suggested, of the chemical treatment of sewage as unsatisfactory. What success had been achieved in certain places was only in the way of abating, not of removing the evil. A long discussion followed, and it was stated that the Board of Control had approved of the sewage scheme. Some of the governors thought the best way out of the difficulty would be to pipe the sewage to the city sewers; but this scheme, it was shown, would be most expensive. Finally, it was settled to refer back the whole matter to the committee for further consideration. It is quite evident that the question of what plan to adopt in reference to the sewage of the Purdysburn Asylum will be a most difficult one.

Armagh Sewage Scheme.

The Armagh Town Commissioners having received a sealed order from the Local Government Board to execute certain work with regard to the sewage of that city, have had plans furnished to them by Mr. Peddie, engineer to the Ulster Sanitary Association, for an entirely new system of sewage, which, I hear, is to provide for disinfection of the sewage on the chemical plan. On April 8th a deputation appeared before the Board urging that if the sewer complained of, and in regard to which the recent investigation was held, was put right the command of the sealed order would be satisfied. They urged that this would be much less expensive than the proposed new scheme. The chairman said that the sealed order went further than the deputation seemed to think. It did not particularise the place complained of, but said that the sewers in the urban sanitary district were to be set right. Even taking the river complained of alone, it would entail a complete renovation of the sewerage of the city. The committee appointed by the commissioners having gone most minutely into the scheme (and most of them were ratepayers themselves), considered that the plan was as cheap a one as could be secured. The report dealing with the site of the sewage works was adopted. As Mr. Peddie had stated there would be no smell from the site of the works, it was decided it should be placed near the city and the expense of carrying it outside the municipal boundary be saved.

The Winter Session at Belfast.

The winter session, both at Queen's College and at Hospital, came to an end on April 11th. The class examinations will be held next week.

The Battle of the Clubs at Cork.

The local papers recently announced that one of the clubs had increased the salary of their recently-appointed medical officer in recognition of the satisfactory manner in which he had discharged his duties. As I do not object to giving further publicity to the generosity of this club, I may mention that a few months ago the members of the club appraised the value of the services of their newly-appointed surgeon at 5*s.* per annum per member, which sum was to pay for attendance on the members *and their families*. The club has now—no doubt after mature deliberation—decided on further augmenting the income of their medical officer by presenting him with an additional shilling. It is recognised on all sides that the present comparatively healthy condition of the city is an aid to the clubs in their contest with the local profession, as few consultations are required, and the amount of work thrown on the imported medical men is well below the average. But if much sickness prevailed the exacting members of societies would soon become discontented owing to their limited staff being unable to visit patients at one and the same time in different parts of the city. The numerous communications received by the local committee indicate the widespread interest taken in the movement initiated by the Cork doctors, and I have no doubt a blow will be struck in various other quarters at the tyranny of the clubs. Even a protest has been raised in far-away Fiji. A letter addressed to one of the newspapers published there has been forwarded to us, in which the writer contrasts the action of working men when as employers they are dealing with members of the medical profession and when, on the other hand, they want to exact for themselves increased wages from the "bloated capitalist." I have but one word to add: the Cork doctors are as united and determined as ever.

The Witchcraft Case at Clonmel.

The magisterial inquiry has resulted in the return of seven of the prisoners for trial on the capital charge; but, from the evidence given on the last day of the investigation, it would appear that the presence of some of the prisoners whilst part of the atrocity was being enacted was due to the fact that the husband of the unfortunate woman flourished a knife which he threatened to use. In that way he compelled one of the men to assist him in burying the body, and prior to its removal he stated that as he could not drive out the devil through the chimney he would drive her out through the door. Afterwards he was evidently seized with remorse on becoming convinced that it was really his own wife that he had so cruelly done to death. The charge against the "herb doctor" was dismissed on the ground that he had no connexion with the case further than prescribing for the poor patient.

The Payment of Locum Tenents of Dispensary Medical Officers.

As I have already mentioned, Mr. Blanchard caused his solicitor to write to the Middleton Poor-law guardians threatening legal proceedings in case they should persevere in refusing to pay him for discharging the duties of one of the dispensing medical officers during the absence of the latter

owing to ill-health. The important question raised was as to whether the guardians or their medical officer should be held responsible to Mr. Blanchard for his fees. The Local Government Board have now decided that the guardians should pay, and this decision will of course rule many other similar cases.

Veterinary College for Dublin.

The preliminary arrangements for the projected veterinary college in Dublin are now well advanced, and the terms of the charter are being considered by the legal authorities. The next important step will be the introduction of a Bill dealing with the financial question.

PARIS.

(FROM OUR OWN CORRESPONDENT.)

The Diagnosis of Diphtheria.

SINCE the important communication of Dr. Roux at Budapest was made, I, doubtless in common with a good many of my *confrères*, made it a matter of routine to determine bacteriologically the nature of any affection of the throat characterised by a secretion deposited on the tonsils. Hitherto it has only been at the laboratory of the enterprising journal, *La Presse Médicale*, that the gratuitous diagnosis of these cases has been possible in Paris, although some capable druggists undertake the task at a moderate price. This lacuna in the arrangements for the prompt tackling of diphtheria has induced the municipal council to create a special department for this purpose at the Laboratory of Micrography of the city of Paris, in the Montsouris Observatory. Here the practitioner will be supplied on application with tubes of gelatinised serum and a spatula for the preparation of the culture at the bedside. The tube returned to the laboratory, the result will be transmitted to the medical man within twenty-four hours. The sum of 10,000 fr. was on April 6th voted towards this laudable object.

Student Soldiers.

It has always been a matter of surprise that the energies of the medical recruit should be wasted on drills and exercises of a purely military character, and that his special knowledge should not rather be utilised in the hospital wards during his term of service. This blind policy was more to be wondered at when it was a matter of common knowledge that, on the outbreak of war, the supply of surgeons would inevitably fall far short of the demand. The present Minister of War has appreciated the incongruity, and has consequently just decided that, after having undergone a short course of instruction in soldiering, student-recruits will in future be employed as *infirmiers* in the wards. Students have cause to rejoice at this sensible decision, for the application of the new regulation will necessarily keep them more in touch with their future occupations, and render their presence in the ranks loss a waste of time, from a medical point of view, than has hitherto been the case.

A Monument to the late Professor Villemin.

On Sunday, the 31st ult., there was unveiled in the Cour Boussais, at the Val-de-Grâce Military Medical School, a statue of the late Dr. Villemin, known to the profession for his remarkable researches into the nature of tuberculosis. The Minister of War was represented by Dr. Colin, *Inspecteur-Général du Service de Santé*, and all the available members of the *Corps de Santé* were present, as well as the students of the Val-de-Grâce and such civilian practitioners as MM. Berger, Landouzy, Hanot, Perrier, Herard, &c. Discourses were delivered by Dr. du Cazal, *médecin-principal*, and Dr. Colin, the latter observing in the course of his remarks that the army surgeon should never forget that he is the chief consoler of the soldier serving far away from his home.

The late Professor Georges Pouchet.

The late regretted Professor of Comparative Anatomy at the Muséum d'Histoire Naturelle, who died on March 29th of last year, and was buried at Père-Lachaise, had gathered round his grave last week a few sorrowing friends come to witness the unveiling of a monumental souvenir of a great *savant*. Two brief discourses were delivered, one being by Dr. Dumontpallier, vice-president of the Société de Biologie, to which corporation the deceased left all his fortune.

VIENNA.

(FROM OUR OWN CORRESPONDENT.)

Rare Diseases of Joints.

AT the last meeting of the Vienna Medical Society Professor Kolisko described some rare diseases of the joints. Syphilitic disease of the joints may be either acute or chronic, the former condition being characterised by serous effusion into the articulation and by inflammatory appearances. He exhibited the knee-joint of a man whose leg had been amputated. The patient's mother had been infected during her pregnancy; he himself has always been healthy, and was the father of healthy children. The joint was ankylosed, the articular surfaces being grown together, with the exception of some narrow spaces. The central parts of the femur were eroded and permeated by a white callus. The surface of this bone was also covered by a layer of osseous substance, which was specially indicative of syphilis. Professor Kolisko describes the following characteristic marks of joint affections associated with tabes: (1) distension of the capsule by serous effusion; (2) proliferations in the synovial membrane; (3) atrophy of the articular extremities; and (4) spontaneous fractures. Contrary to the opinion of French writers, who assume a trophic disturbance, Professor Kolisko explains these processes on the theory that through the insensibility resulting from tabes dorsalis the patient does not feel concussions, and does not fix his joints. If an articulation affected with a neuropathic disease were fixed in an early stage the process could be stopped. French authorities affirm that in spontaneous fractures the bones become porous in consequence of inflammation of their nerves; but Professor Kolisko supposes the incoördination of movement and the want of support from normal muscular action to be the true causes. A third rare disease of the joints is arthritis pauperum, which is very painful, and only attacks the small articulations of the hands and feet of people exposed to privations. The joints are flexed, proliferations occur on the articular extremities, and there may be displacement of the first phalanx on the head of the metacarpal bone.

Death of Dr. Gauster.

By the death of Dr. Gauster, who passed away on March 25th, the profession of medicine in Vienna loses one of its best known members. Born in Vienna about sixty-eight years ago, he studied at the School of Medicine there, and eventually adopted lunacy as his special subject. Immediately on obtaining his diploma, in 1851, he became assistant director of the Lunatic Asylum of Lower Austria, and in 1888, Professor Schlager having died, he was appointed director. In the fulfilment of his responsible duties he gained universal esteem. His principal works were: Moral Insanity, 1879; Mental Degenerations, and the Influenza Epidemic in the Vienna Lunatic Asylum in 1889–90, and its Influence on Phrenopathics. He was also on the Council of Hygiene. Dr. Gauster succumbed to an attack of pneumonia. The funeral took place on March 28th, and was attended by a large gathering of Vienna medical men.

Blindness caused by a Vermifuge.

Dr. Gross[1] relates the following case. A man aged forty-four years after a dose of castor-oil took thirty-two capsules of a vermifuge. In the evening he fainted away, and when admitted to the hospital was found to be suffering from mydriasis and total want of light perception, but without visible change in the fundus oculi. Symptoms of atrophy of the optic nerve subsequently appeared. Each capsule contained ethereal extract of male fern and pomegranate root bark, of each 0·25 gramme (4 grains) Dr. Gross recommends calomel given in half-gramme doses (= 7½ grains) as far the most satisfactory of all the numerous remedies proposed for tænia solium.

The Otological Society.

The inaugural meeting of this society took place on March 28th. Its purpose is the promotion of aural surgery by means of scientific reports, demonstrations, discussions at the meetings, and an annual congress. Professor Josef Gruber was elected president; Professor Pollitzer, vice-president; Professor Urbantschitsch, manager; and Dr. Pollak, secretary.

April 7th.

[1] Pester Medicinisch-chirurgische Presse.

CANADA.

(FROM OUR OWN CORRESPONDENT.)

The Patrons of Industry and the Ontario Medical Act.

As indicated some months ago, this new political party proposed to introduce a measure which would greatly alter the existing law regarding the practising of medicine in this province. That they have been true to their promise is quite evident from the Bill presented to the Legislature on March 8th last, whilst for brevity it is to be commended, being composed of only eighteen sections; yet for a measure to lay before a House it seems but the offspring of ignorance, and as a result iniquitous. The Ontario Medical Act as at present in the Revised Statutes is the result of legislation at different times since 1850, and has been considered as good a Medical Act as can be found in any country, and now this particular political party, pursuing a destructive course, apparently aims at free trade in medicine. As an example of the destructive process, Section 3 reads: "Sections 17, 18, 20, 23, 25, 26, 27, 30, 31, 33, 34, 35, 36, 37, and 38 of the said Act (the Ontario Medical Act) are repealed." Section 4 is somewhat like it, and refers to the Act of 1891: "Sections 1, 3, 4, 5, 6, 7, and 8 of the Act passed in the fifty-fourth year of Her Majesty's reign are repealed." The purport of the proposed legislation is to take away the powers at present possessed by the Medical Council to control examination and registration, handing them over to the Government under the Department of Education, all fees from examinations to be funded with the provincial treasurer. The Board of Medical Education is to consist of three members of the Medical Council, one representative of each medical school, two homœopaths, and two appointed by the Government, and the fee for registration is placed at the figure most suited to the farmer's pocket—viz., $5 or £1. The power of removal of name from the Roll is taken from the Council and vested in the senior county court judge. "Unworthy conduct" includes fraudulent advertising, habitual drunkenness, transmission of contagion or infection, or any violation of the Public Health Act, the issuing of false or blank death certificates, neglect to register births and deaths, conviction in any action for damages from injury, and negligence, ignorance, or want of skill. The time of limitation for malpractice is extended from one to two years. Section 16 relates to the licensing of midwives, and is in keeping with the other clauses of the Act. It is sought to license any woman of "good character" who proves by evidence "taken on oath before" any local board of health "that she has successfully performed the office of midwife in at least ten cases of confinement"; she shall on payment of the nominal fee of 4*s.* 2*d.* to the treasurer of the municipality be licensed to practise midwifery in the municipality for two years. The framer of the Bill has added the words, renewable upon "the production of similar evidence of good character." The licensed (!) modern "Sairy Gamps" are to be protected from the penalty for practising without registration and for falsely pretending, a proviso which I think entirely nullifies the provisions for licensing. The measure virtually permits the practice of midwifery by any woman. Sufficient has been stated of this Bill to indicate the manner the "Patrons of Industry," who claim to represent the farming community, wish to treat the practice of medicine in Ontario.

Provincial Expenditure on Hospitals &c.

Last year the revenue derived from succession duties was applied to the maintenance of hospitals and charities. The estimated revenue was $70,000, whilst the actual amount received was over $150,000, being only $40,000 short of the amount actually expended on these institutions. The provincial treasurer, in his Budget speech, stated that he hoped in the near future the revenue from the succession duties would cover the grants under this head.

Insane Asylums in Ontario.

The seven institutions of the province have accommodation for 4586 patients. On Dec. 31st, 1894, there were 4441 inmates. That the service is efficient no one denies, that cost of management is kept at a low figure is a fact, but I cannot but notice that the Government are receiving medical services of a high quality at a figure much below that usually paid on this continent, and I venture to say that the salaries of those in this particular service might be increased without a charge being made of "high salaries." It would appear that the Government make a boast of paying low salaries to professional employés, for the Budget states that, whilst the cost *per capita* for medical service in New York State is $14·34, yet in the province it is only $5·33. In the case of employés the comparison is not so great, being $70·63 in New York to $32·17 in Ontario, and the cost per inmate in the adjoining State is $184·77 to $127·32 with us, the difference of salaries paid to the medical staffs being nearly $40,000.

Insurance Murders.

Public attention has for the past few weeks been directed to several cases of this class. In one in the western portion of the province the deceased was found under a fallen tree, it being claimed that death was due to the blow received from the falling tree; there had recently been over £6000 of insurance placed upon the victim's life. As a result of the inquest two persons were committed, charged with the murder, both being found guilty at the assize and sentenced to be hanged, since which one has confessed that they first killed their victim with an axe, placing subsequently the body under the fallen tree. The second case is more complicated, owing to the deed with which two are charged having taken place nearly three years ago in Toronto. A young man upon whose life there was a large insurance was supposed to have been accidentally killed by the weight (200 lb.) of a hoist having fallen and crushed his skull. Suspicion was not aroused until insurance was sought for—some £60,000—upon his sister's life, who in the meantime had married one of two brothers in whose warehouse the supposed accident happened. The body has been exhumed, and the evidence of the medical experts at the preliminary investigation is alleged to show that the injuries to the skull were not caused by the hoist weight. The two brothers are now awaiting trial on a charge of murder.

Toronto.

Obituary.

JAMES HARMER SOMERVILLE, M.R.C.S. ENG., L.S.A.

THE announcement of the death of Mr. Somerville has caused profound sorrow in Bloxwich and the adjoining parts of the county of Stafford, where his family had long been domiciled, and where he himself had for many years in his professional capacity enjoyed the confidence and esteem of all ranks of society. His father, the late Mr. James Somerville, was a well-known practitioner in the district, and was in due course succeeded by his son, who gained the diploma of the Royal College of Surgeons of England in 1861 and that of the Society of Apothecaries in 1863. Activity and energy were the distinguishing features of Mr. Somerville's character. He acquired some prominence in the local political organisations, and delighted in outdoor sports as long as his strength permitted. Latterly, however, his health declined, and, though not more than fifty-five years of age, he found his strength unequal to the fatigues of his extensive practice. It was hoped that a visit to Hastings would be beneficial, but a residence there of some weeks did not produce the desired result, and the end came peacefully on March 28th. The funeral took place at Bloxwich churchyard on April 1st, and was attended by a very large gathering of sympathising friends and by a company of the 2nd Battalion South Staffordshire Regiment of Volunteers, to which the deceased was assistant surgeon. Mr. Somerville was twice married and is survived by his widow. His eldest son resides in Walsall.

JOHN REEKS, M.R.C.S. ENG., L.S.A.

THE announcement of the death of Mr. John Reeks, which took place at his residence at Southwick, Sussex, on April 5th, was received with profound regret by his friends and patients. Mr. Reeks had an attack of influenza some three or four weeks ago, from which he really never recovered. Born at Elcott, in Berkshire, he was educated at Newbury, in the same shire. In 1879 he went to St. Bartholomew's Hospital, where he gained the degrees of M.R.C.S. Eng. and L.S.A. in 1884. For some time he was the assistant medical officer at the small-pox camp at Darenth, and was in practice for several years at Forest Gate. In 1887 he went to Southwick,

succeeding the late Mr. Nathaniel Jarvis. Mr. Reeks was most popular in the district, where he had an extensive practice, and his demise leaves a notable blank in local society.

DEATHS OF EMINENT FOREIGN MEDICAL MEN.—The death of the following eminent foreign medical man is announced:—Dr. Moritz Gauster, Director of the Lower Austria Insane Asylum. The most notable of his earlier papers, while he was district medical officer in Stein, was one on the Infection of Human Subjects by Anthrax. This attracted the attention of the Government, and he was called to Vienna and appointed member of the Medical Council. He took a great interest in popularising hygienic knowledge and wrote a manual on this subject for schoolmasters. He also published a good many papers in professional journals and annuals on Mental Disease, especially on its connexion with Alcoholism and Influenza.

Medical News.

EXAMINING BOARD IN ENGLAND BY THE ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.—The following gentlemen passed the Second Examination of the Board in the subjects indicated:—

Wednesday, April 3rd:—

Anatomy and Physiology.—Lawrie Hugh McGavin, Joseph Elford Dupigny, and Herewold Evelyn Croker Fox, students of Guy's Hospital; Matthew Henry Gregson Fell and Richard Harte Lloyd, St. Bartholomew's Hospital; Ernest Charles Lambert and Walter Biscombe Silas, Westminster Hospital; John Charlton Briscoe, George Augustus Roberts, Colton Taylor Lewis, and Frederick Augustus Hadley, King's College, London; Harold Douglas Singer, St. Thomas's Hospital; Frank Atthill and Harold Arthur Thomas Fairbank, Charing-cross Hospital; Harold Shuttleworth Barwell, St. George's Hospital; Thomas Henderson Dugon, London Hospital; George Baynton Forge, London Hospital and Mr. Cooke's School of Anatomy and Physiology.

Anatomy only.—Mr. George Fernandez Mitchell Clarke, Charing-cross Hospital.

Nineteen gentlemen were referred in both subjects and two in anatomy only.

Thursday, April 4th:—

Anatomy and Physiology.—Joseph Arthur Mawson, Yorkshire College, Leeds; Gilbert Bahn Thwaites, Bertram Mitchell Young, and John Francis McClean, St. Thomas's Hospital; Parkinson Osborne Gruber, St. Bartholomew's Hospital; William Ellis Morgan, Charing-cross Hospital; Theodore Marles-Thomas, John Llewelyn Jones, and Campbell Dykes, University College, London; Henry Neville Coltart, St. George's Hospital; George Louis Atkinson and Thomas Hudson Gardiner, King's College, London; Arthur Trevor Richardson-Jones, Oxford University and King's College, London; Harold Sugden Crapper, Guy's Hospital; Robert McKay, Middlesex Hospital; John Mayor Wilson, Middlesex Hospital and Royal College of Surgeons, Edinburgh; Hillel Jacob Farhi, Syrian Protestant College, Beyrut, and London Hospital; and Wilfred Joseph Lubeck, Medical College and University, Madras.

Anatomy only.—Martin Clover, University College, London.

Physiology only.—Thomas Howard Body, Guy's Hospital; and Frederick Arthur Johns, London Hospital.

Fourteen gentlemen were referred in both subjects, two in anatomy, and two in physiology.

Friday, April 5th:—

Anatomy and Physiology.—Stanley William Randolph Colyer, Charing-cross Hospital; Frank Fouracre Bond, Westminster Hospital; William Taylor Milton, Philip Turner, Charles Leopold Granville Chapman, Robert Fell, Septimus Benjamin Cullen Carter Adolphus Pennington and Thomas Percival Berry, Guy's Hospital; David Samuel Robert Halstead Dixon, Edmund Howard Barrett, and Alexander Stoker Gardiner, St. Mary's Hospital; William Trethowan Rowe and Robert Raines, St. Bartholomew's Hospital; John Alfred Barnes, John Ellis Kilvert, and Thomas Hoban, St. Thomas's Hospital; Montague Dixon and Percy Glyn Savours Williams, University College, London; Walter Biggar Bannerman and Ralph Norman, London Hospital.

Anatomy only.—Harold Charles Harrison, St. Bartholomew's Hospital; and Ernest Urquhart Bartholomew, Charing-cross Hospital.

Thirteen gentlemen were referred in both subjects, and one in anatomy only.

Monday, April 8th:—

Anatomy and Physiology.—Robert Crasker Leaning, Harold Dyer, Frank Charles Lewis, and Frank Sherwill Dawe, St. Mary's Hospital; Seymour Alfred Millen and William Christopher Long, St. Bartholomew's Hospital; Frederick Edward Walker, Francis John Hensley Martin, Walter Henry Maxwell Telling, Francis Harold Rodier Heath, Herbert Melbourne Berncastle, Arthur Ernest Clarke, and Eugene Gilbert Goddard, Guy's Hospital; Sydney Oliphant Bingham, Henry Harold Scott, and Edward Alfred Gates, St. Thomas's Hospital; Humphry Morshead Hart-Smith, Cambridge University and University College, London; Carol Luther Betteson, Cyprian Royston Pike, George Heywood Herbert, and Clement Woodthorpe Chaplin, London Hospital; Arthur Martin-Leake, University College, London; Edward Protheroe Smith and Leslie Milburn, Middlesex Hospital.

Twelve gentlemen were referred in both subjects.

Tuesday, April 9th:

Anatomy and Physiology.—Shaik Abdur Ruzzak, Herbert Lightfoot Eason, Alfred Cole Ambrose, and William Mussellwhite, Guy's Hospital; Angus Joseph McNab Cudden-Fletcher, St. Bartholomew's Hospital; Ralph Albert Rogers Lankester, University College Hospital; George Winn and Irwin Walker William Hunter, London Hospital; Thomas Jones, Arthur Ernest Relph, and George Humphry Lucas, Middlesex Hospital; and Alexander Fleming Millar, St. Thomas's Hospital.

Anatomy only.—Alfred Edward Seller and John Maclean Carvell, of London Hospital; Charles Walter Gibson, of Guy's Hospital; Phillip Phillips, of Charing-cross Hospital; and Albert Ernest Street, of Charing-cross Hospital, and Mr. Cookes, School of Anatomy and Physiology.

Physiology only.—Frank Howard Lawson, of Middlesex Hospital; Nicolas Buencia, of University of Colombia, and Cecil Edward Andrews, of London Hospital.

Thirteen gentlemen were referred in both subjects, five in anatomy, and five in physiology only.

UNIVERSITY OF GLASGOW.—The following have passed the first professional examination (old regulations) for the degrees of Bachelor of Medicine (M.B.) and Master in Surgery (C.M.):—

Thomas Small Goodwin, Charles David Picken, Alex. J. T. Swann, and Ernest M. Watkins.

The following have passed the first professional examination (new regulations) for the degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.) in the subject or subjects indicated after their respective names (B., Botany; Z., Zoology; P., Physics; C., Chemistry):—

James Napier Baxter (B., P.), James Freeborn Bennett (Z., C.), William Bennett (B.), William Broad (B., Z., C.), Andrew Brownlie (P.), John Brunton (B., P.), Thomas Bullough Calland (B., C.), Ranald Douglas Campbell (P., C.), James Carruthers, M.A. (P.), Alexander Henderson Cassells (Z., C.), James Robert Chalmers (Z., C.), Andrew Clark (B.), David Maclure Cowan (Z., C.), George Morris Crawford (B., P.), John Cullen (P., C.), Charles Cheven Cumming (Z., P.), Archibald William Wallace Davidson (Z., P.), David William Davidson (Z., C.), John Lithgow Davie (B., P.), James Dick (Z., P.), James Austin Dickie (Z., P.), Frank Lindsay Dickson (Z.), James Drummond (P., C.), Comyn MacGregor Finlay (Z., P.), Matthew Wm. Fraser (Z., P.), John Andrew Garden (B., P.), John Gracie (B., P.), George Henry Fullarton Graves (Z.), Archibald Wilson Harrington (Z., P.), Leslie Charles Broughton Head (Z., P.), John Henderson (C.), Isaac Mackay Huey (Z., P., C.), Thomas Inglis (Z.), Robert Dallas Kennedy (B., P.), Andrew Kerr (Z., P.), David Littlejohn (B., C.), James Grant Miller (Z., P.), Ramsay Millar (Z., P.), Hugh Miller (P.), Norman Macleod Miller (Z., P.), Alexander MacCulloch (B., C.), James Hogg MacDonald (Z., P.), Archibald Turner Macewan (P., C.), Peter MacIntosh M'Fadyen (Z., P.), John M'Gilchrist (Z., P.), David Duncan Fraser Macintyre (B., P.), Charles Forbes Maclean (Z., P.), Norman Forbes MacLeod (Z., P.), William Johnston Maclure (B., P.), Alfred Robert Maclurkin (Z., C.), John M'Millan (B., P.), Roderick Reid Macneicol, M.A. (C.), Thomas Neill (B., P.), John Patton (B., Z., C.), Thomas Stephens Picken (Z., P.), William Barr Inglis Pollock B., P.), Arthur Robin (Z., P.), James Scott, M.A. (Z., C.), John Shaw, M.A. (Z., C.), James Shearer (B., Z., P., C.), Andrew James Smith (Z., P.), David James Smith (Z., P.), James Smith (P., C.), James Johnston Smith (B., C.), William Stewart Stalker (P., C.), Alfred George Stewart (Z., C.), Frederick Richardson Stewart (B., C.), James Douglas Brownlee Stewart (B., C.), Peter Donald Strachan, M.A. (B., C.), James Alexander Sutherland (B., P.), Charles Pinkerton Thomson (Z.), William Brown Thomson (B., P.), Thomas Bird Tierney (P., C.), Alexander Laurie Watson, M.A. (Z., P.), Alexander Simpson Wells (Z., C.), Robert Orr Whyte (B., Z., P., C.), George Henry Wildish (Z., P.), Morgan Watkin Williams (P.), Alexander Wilson (Z., P.), William Wright (Z., P.), and John Doctor Young (Z., C.).

Women candidates.—Sarah Davidson (P., C.), Marjorie King Henderson Fleming (P., C.), Jessie Downie Granger (P., C.), Mabel Hardie (P., C.), Jessie Sophia Beatrix Hunter (P., C.), Mary Longmire (B., P.), Jane Lorimer (C.), Annie Louise M'Ilroy (B., C.), Ina Lochhead M'Neill (P., C.), Mary Lauchline M'Neill (Z., P.), Sara Maude Robertson (P., C.), Maud Spencer (P., C.), Gertrude Florence Fleetwood Taylor (P.), and Grace Lorrain Young (P., C.).

The following have passed the Second Professional Examination (old regulations) for the degrees of Bachelor of Medicine (M.B.) and Master in Surgery (C.M.):—

William Buchan Armstrong, John Tait Bowie, John Ritchie Burns, James Banks Cumming, John James Edgar, George Louis Le Fevre, Robert Hugh Meikle, John Allan Craigie Macewen, William Fullerton M'Ewen, Archibald M'Glashan, Lionel Mitchell Mackay, William M'Mullen Pearson, James Hood Rankin, James Rutherfurd Ratcliffe, Robert Shanks, Joseph Sillars, Archibald Stevenson, and David Lyon Stevenson, M.A.

The following have passed the Second Professional Examination (new regulations) for the degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.) in the subject or subjects indicated after their respective names (A., Anatomy; P., Physiology; M.M. and T., Materia Medica and Therapeutics):—

Alexander Smith Allan (A., P.), Theodore Belchambers Broadway (A., P.), David Louis Cairns (A., P.), Francis James Charteris (A., P.), Joseph Adam Clarke (A., P.), George William Coats (A., P.), James Duncan Cochran (A., P.), Walter Scobie Findlay, M.A. (A. P.), James Finlayson Fleming (A., P.), Adrian Andrew Forrester (A., P.), Lawrence Whitaker Harrison (A., P., M.M. and T.), Alexander Lawrie (A.), William Mitchell Lindsay (A., P., M.M. and T.), William Glen Liston (A., P., M.M. and T.), John MacDonald (A., P.), James M'Haffie (A., P.), David M'Kail (A., P.), James M'Queen, M.A.

(A., P.), Normal Emil Henry Scott (A., P.), Alexander Bankier Sloan (A., P.), Samuel Macfarlane Sloan (A., P.), David Steele Smith (A., P.), James Strang (A., P.), Matthew Logan Taylor (A., P.), Walter Lewis Thomson (A., P.), William Watson (A., P.), Ernest Watt (A., P.), Edward Roberts Weir (A., P.), William Wyper (A., P.), and David John Young (A., P.).

Women candidates.—Daisy Annabella Murdoch Clark (A., P.), Margaret Elizabeth M'Neill (A., P.), and Jessie Hawkesworth Smith (A., P.).

The following have passed the third professional examination for the degrees of Bachelor of Medicine (M B) and Master in Surgery (C.M.):—

A., including Pathology.—John Allan, Samuel Anderson, B.Sc., John Ritchie Brown, William Burns, Malcolm Campbell, John Divine, Matthew Dunning, Thomas M'Gibbin Fletcher, Daniel M'Intyre Glen, George Hanson, Allen Iredale, John William Jackson, John Knight, John Walker Munro, William Milroy M'Farlane, John Souttar M'Kendrick, Hugh M'Laren, John M'Laws, Thomas Duncan Newbigging, Harry Couper Patrick, David Shedden Service, James Craik Taylor, Noel Charles Echlaz Ward, Henry Whitehouse, and James Eric Wilson.

Women candidates.—Mary Baird Hannay and Madge Speirs Maclean.

B., not including Pathology.—Alfred Charlton, Duncan Drummond, George Henry Beck Harvie, Robert Hastie, James Hogg, Edwin Brooke Jago, John Marshall, Samuel Martyn, John Robert Gordon Phillips, James Malloch Robertson, Neil Robson, Wm. Kerr Russell, and Ernest Fred. Docetti Walker.

ROYAL COLLEGE OF SURGEONS IN IRELAND.—SCHOOLS OF SURGERY.—Class prizes winter session, 1894-95. Descriptive Anatomy: Junior, W. J. Anglim, first; H. M. Clarke and J. M. Crawford (equal), second; senior, F. J. Palmer, first, and R H. D. Pope, second. Practical Anatomy: First year, S. R Godkin, first, and J. J. Huston, second; second year, M. W. Falkner, first, D Hadden and J. Leventon (equal), second; third year, A S. Greene, first, and A. McMunn, second. Practice of Medicine: D. Kennedy, first, and W. M. Power, second. Theoretical Surgery: A. I. Eades, first, and D. Kennedy, second. Midwifery: G. A. Robinson, first, and J. A. McMunn, second. Physiology: F. J. Palmer, first, and D. Hadden, second. Chemistry: W. J. Anglim, first, and S. R. Godkin, second. Pathology: G. A. Robinson, first. Physics: W. J. Anglim and D. A. Fitzgerald (equal), first, and M. Gavin, second. The schools opened on Monday, April 1st, for the three months' courses of Operative Surgery, Practical Chemistry, Pharmacy, Public Health, Forensic Medicine, Materia Medica, Histology, Biology, and Dissections.

SOCIETY FOR THE PREVENTION OF HYDROPHOBIA AND REFORM OF THE DOG LAWS.—A meeting of the General Committee of the Society for the Prevention of Hydrophobia was held on the 8th inst. at 25, Cavendish-square, W., Professor Victor Horsley, F R.S., in the chair. In the chairman's report reference was made to the communications which had passed between the Board of Agriculture and the society's executive on the subject of the Dogs Bill, and also to the prevailing epidemic of rabies and hydrophobia in Yorkshire, Lancashire, and other northern counties and in Ireland. It was pointed out that but for political considerations the policy advocated by the society and endorsed by the highest medical authorities, as well as by many of the most important dog-breeders and dog-owners throughout the country, would doubtless be carried into effect by the Government of the day. It would only be when the pressure of these combined forces of instructed and responsible opinion became too great for any Government safely to resist that the object for which the society was formed would be accomplished. This object, it was needless to say, was the total extinction of rabies and hydrophobia from the United Kingdom by a system of universal muzzling for at least twelve months, coupled with rigid and permanent quarantine. The attitude of the general public, except during the scare created by an epidemic of rabies, was one of apathy and indifference. It was useless therefore to expect the assistance which many causes derive from a public movement or demonstration in their favour. The aims the society had in view would therefore be best promoted by securing the increased adherence of members of the medical profession and men of influence generally (especially of those recognised as leaders of opinion in canine matters), so that when the proper moment arrived the society would have sufficient support behind it to convince any Government that the subject was not a question of party politics, but of public welfare. Since the last meeting of the committee liberal contributions to the funds of the society have been received from the Duke of Northumberland (president of the society), the Duke of Westminster, the Earl of Coventry, Sir Joseph Lister, Bart., Sir James Whitehead, Bart., and many others.

PUBLIC BATHS IN SOUTHWARK.—The vestry of the parish of St. Saviour, Southwark, have erected public baths and wash-houses in Lavington-street, at a cost of £40,000, inclusive of £10 000 for the site. There are two swimming baths, the first-class, which is 120 ft. long by 48 ft. wide, and the second-class, which is rather smaller. There are also first and second-class private baths, and in the wash-houses separate compartments are provided for twenty-four workers. The formal opening took place on April 6th, in presence of a large company.

NORTH RIDING INFIRMARY, MIDDLESBROUGH.—The annual meeting of this hospital was held on April 4th, Alderman J. F. Wilson, J P., presiding. The report showed that there had been a considerable increase in the number of in-patients, and that the expenditure had exceeded the income by £108. Adding the deficiency brought forward from the previous year, the total indebtedness is £252, for the diminution of which special efforts are being made by public appeals and by an exhibition to be held in the town hall in the autumn. There is great need for a new operating room, the estimated cost of which is £900.

CIVIL RIGHTS DEFENCE COMMITTEE (PRESIDENT, THE RIGHT HON. THE EARL OF STAMFORD).—The Committee append a further list of subscribers to the Anderson Privy Council Appeal Fund. At the meeting of the Committee on March 15th, 1895, the following resolution, moved by General Graham and seconded by Mr. Foulerton, was unanimously adopted: "That the thanks of the Civil Rights Defence Committee are due and are hereby tendered to Dr. Branch and the members of the Leewards Branch of the British Medical Association for their generous and practically unanimous support to this committee in the defence of the civil rights involved in Mr. Anderson's case and for their support and sympathy with Mr. Anderson in his arduous and protracted struggle for the defence of these rights. That such support, coming from the West Indies, where the attack upon those rights occurred, is of special value, and is especially appreciated by the committee." Additional subscribers to the Anderson Privy Council Appeal Fund to March 31st, 1895:—

Anonymous sympathiser, per Mr. A. M. Lee		£1	1 0
Dr. Dukes, Rugby, as per list—			
Mr. T. Duke, M.A., Rugby	£0 5 0		
Mr. Sutton Pratt, Rugby	0 5 0		
Mr. Bernard Relton, Rugby	0 5 0		
Mr. W. A. E. Waller, Rugby	0 5 0		
Dr. J. H. Simpson, Rugby	0 10 6		
		1	10 6
Mr. W. G. Groves, Woodford Green		0	5 0
Members of the Leeward Islands Branch of the British Medical Association (collected by Dr. W. J. Branch, St. Kitts)—			
Mr. J. D. Bell, Nevis	0 10 0		
Dr. W. J. Branch, St. Kitts	1 1 4		
Dr. J. H. Cooke, Nevis	0 10 0		
Mr. M. P. Duke, Montserrat	0 10 6		
Mr. A. B. Edwards, Antigua	0 10 6		
Mr. W. H. Edwards, Antigua	1 1 0		
Mr. J. Foreman, St. Kitts	0 10 6		
Dr. F. J. Freeland, Antigua	0 10 6		
Mr. W. H. Fretz, St. Kitts	1 0 10		
Mr. J. S. Gabriel, Antigua	0 10 6		
Dr. P. J. Huggins, Nevis	0 10 0		
Dr. G. H. Mapleton, St. Kitts	1 0 10		
Dr. H. A. Nicholls, Dominica	1 1 0		
Dr. F. L. Norris, Montserrat	0 10 6		
Mr. J. N. Rat, St. Kitts	0 10 6		
Mr. R. E. Semper, St. Kitts	0 10 6		
Mr. A. L. Wykeham, Antigua	1 1 0		
		12	0 0

It is particularly requested that all subscriptions to the present fund be sent direct to the Manager of the Union Bank of London (Chancery-lane Branch) and be made payable to the "Anderson Appeal Fund Account."

THE REMUNERATION OF DISTRICT MEDICAL OFFICERS IN WALSALL.—The sick poor of Walsall are likely to be the gainers by the settlement of a question at issue between the board of guardians and one of their medical officers. This gentleman, having stated that he was unable without assistance satisfactorily to fulfil the duties of his office, the finance committee of the board recommended that a grant of £15 be made to him for cab hire in urgent cases. This proposal of the committee was not endorsed by the board, but at a subsequent meeting held last week wiser counsels prevailed, and the advocates of economy made a tardy retreat from their indefensible position. Dr. McKinstry is to be commended for the firmness of his attitude under the circumstances.

succeeding the late Mr. Nathaniel Jarvis. Mr. Reeks was most popular in the district, where he had an extensive practice, and his demise leaves a notable blank in local society.

DEATHS OF EMINENT FOREIGN MEDICAL MEN.—The death of the following eminent foreign medical man is announced:—Dr. Moritz Gauster, Director of the Lower Austria Insane Asylum. The most notable of his earlier papers, while he was district medical officer in Stein, was one on the Infection of Human Subjects by Anthrax. This attracted the attention of the Government, and he was called to Vienna and appointed member of the Medical Council. He took a great interest in popularising hygienic knowledge and wrote a manual on this subject for schoolmasters. He also published a good many papers in professional journals and annuals on Mental Disease, especially on its connexion with Alcoholism and Influenza.

Medical News.

EXAMINING BOARD IN ENGLAND BY THE ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.—The following gentlemen passed the Second Examination of the Board in the subjects indicated:—

Wednesday, April 3rd:—

Anatomy and Physiology.—Lawrie Hugh McGavin, Joseph Elford Dupigny, and Herewold Evelyn Croker Fox, students of Guy's Hospital; Matthew Henry Gregson Fell and Richard Harte Lloyd, St. Bartholomew's Hospital; Ernest Charles Lambert and Walter Biscombe Silas, Westminster Hospital; John Charlton Briscoe, George Augustus Roberts, Colton Taylor Lewis, and Frederick Augustus Hadley, King's College, London; Harold Douglas Singer, St. Thomas's Hospital; Frank Atthill and Harold Arthur Thomas Fairbank, Charing-cross Hospital; Harold Shuttleworth Barwell, St. George's Hospital; Thomas Henderson Dugon, London Hospital; George Baynton Forge, London Hospital and Mr. Cooke's School of Anatomy and Physiology.

Anatomy only.—Mr. George Fernandez Mitchell Clarke, Charing-cross Hospital.

Nineteen gentlemen were referred in both subjects and two in anatomy only.

Thursday, April 4th:—

Anatomy and Physiology.—Joseph Arthur Mawson, Yorkshire College, Leeds; Gilbert Bahn Thwaites, Bertram Mitchell Young, and John Francis McClean, St. Thomas's Hospital; Parkinson Osborne Gruber, St. Bartholomew's Hospital; William Ellis Morgan, Charing-cross Hospital; Theodore Marles-Thomas, John Llewelyn Jones, and Campbell Dykes, University College, London; Henry Neville Coltart, St. George's Hospital; George Louis Atkinson and Thomas Hudson Gardner, King's College, London; Arthur Trevor Richardson-Jones, Oxford University and King's College, London; Harold Sugden Crapper, Guy's Hospital; Robert McKay, Middlesex Hospital; John Mayor Wilson, Middlesex Hospital and Royal College of Surgeons, Edinburgh; Hillel Jacob Farhi, Syrian Protestant College, Beyrut, and London Hospital; and Wilfred Joseph Lubeck, Medical College and University, Madras.

Anatomy only.—Martin Clover, University College, London.

Physiology only.—Thomas Howard Body, Guy's Hospital; and Frederick Arthur Johns, London Hospital.

Fourteen gentlemen were referred in both subjects, two in anatomy, and two in physiology.

Friday, April 5th:—

Anatomy and Physiology.—Stanley William Randolph Colyer, Charing-cross Hospital; Frank Fouracre Bond, Westminster Hospital; William Taylor Milton, Philip Turner, Charles Leopold Granville Chapman, Robert Fell, Septimus Benjamin Cullen Carter Adolphus Pennington and Thomas Percival Berry, Guy's Hospital; David Samuel Robert Halstead Dixon, Edmund Howard Barrett, and Alexander Stoker Gardiner, St. Mary's Hospital; William Trethowan Rowe and Robert Raines, St. Bartholomew's Hospital; John Alfred Barnes, John Ellis Kilvert, and Thomas Hoban, St. Thomas's Hospital; Montague Dixon and Percy Glyn Savours Williams, University College, London; Walter Biggar Bannerman and Ralph Norman, London Hospital.

Anatomy only.—Harold Charles Harrison, St. Bartholomew's Hospital; and Ernest Urquhart Bartholomew, Charing-cross Hospital.

Thirteen gentlemen were referred in both subjects, and one in anatomy only.

Monday, April 8th:—

Anatomy and Physiology.—Robert Crasker Leaning, Harold Dyer, Frank Charles Lewis, and Frank Sherwill Dawe, St. Mary's Hospital; Seymour Alfred Millen and William Christopher Long, St. Bartholomew's Hospital; Frederick Edward Walker, Francis John Hensley Martin, Walter Henry Maxwell Telling, Francis Harold Rodier Heath, Herbert Melbourne Berncastle, Arthur Ernest Clarke, and Eugene Gilbert Goddard, Guy's Hospital; Sydney Oliphant Bingham, Henry Harold Scott, and Edward Alfred Gates, St. Thomas's Hospital; Humphry Morshead Hart-Smith, Cambridge University and University College, London; Carol Luther Betteson, Cyprian Royston Pike, George Heywood Herbert, and Clement Woodthorpe Chaplin, London Hospital; Arthur Martin-Leake, University College, London; Edward Protheroe Smith and Leslie Milburn, Middlesex Hospital.

Twelve gentlemen were referred in both subjects.

Tuesday, April 9th:

Anatomy and Physiology.—Shaik Abdur Ruzzak, Herbert Lightfoot Eason, Alfred Cole Ambrose, and William Musselwhite, Guy's Hospital; Angus Joseph McNab Cudden-Fletcher, St. Bartholomew's Hospital; Ralph Albert Rogers Lankester, University College Hospital; George Winn and Irwin Walker William Hunter, London Hospital; Thomas Jones, Arthur Ernest Relph, and George Humphry Lucas, Middlesex Hospital; and Alexander Fleming Millar, St. Thomas's Hospital.

Anatomy only.—Alfred Edward Seller and John Maclean Carvell, of London Hospital; Charles Walter Gibson, of Guy's Hospital; Philip Phillips, of Charing-cross Hospital; and Albert Ernest Street, of Charing-cross Hospital, and Mr. Cookes, School of Anatomy and Physiology.

Physiology only.—Frank Howard Lawson, of Middlesex Hospital; Nicolas Buencla, of University of Colombia, and Cecil Edward Andrews, of London Hospital.

Thirteen gentlemen were referred in both subjects, five in anatomy, and five in physiology only.

UNIVERSITY OF GLASGOW.—The following have passed the first professional examination (old regulations) for the degrees of Bachelor of Medicine (M.B.) and Master in Surgery (C.M.):—

Thomas Small Goodwin, Charles David Picken, Alex. J. T. Swann, and Ernest M. Watkins.

The following have passed the first professional examination (new regulations) for the degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.) in the subject or subjects indicated after their respective names (B., Botany; Z., Zoology; P., Physics; C., Chemistry):—

James Napier Baxter (B., P.), James Freeborn Bennett (Z., C.), William Bennett (B.), William Broad (B., Z., C.), Andrew Brownlie (P.), John Brunton (B., P.), Thomas Bullough Calland (B., C.), Ranald Douglas Campbell (P., C.), James Carruthers, M.A. (P.), Alexander Henderson Cassells (Z., C.), James Robert Chalmers (Z., C.), Andrew Clark (B.), David Maclure Cowan (Z., C.), George Morris Crawford (B., P.), John Cullen (P., C.), Charles Cheven Cumming (Z., P.), Archibald William Wallace Davidson (Z., P.), David William Davidson (Z., C.), John Lithgow Davie (B., P.), James Dick (Z., P.), James Austin Dickie (Z., P.), Frank Lindsay Dickson (Z.), James Drummond (P., C.), Comyn MacGregor Finlay (Z., P.), Matthew Wm. Fraser (Z., P.), John Andrew Garden (B., P.), John Gracie (B., P.), George Henry Fullarton Graves (Z.), Archibald Wilson Harrington (Z., P.), Leslie Charles Broughton Head (Z., P.), John Henderson (C.), Isaac Mackay Huey (Z., P., C.), Thomas Inglis (Z.), Robert Dallas Kennedy (B., P.), Andrew Kerr (Z., P.), David Littlejohn (B., C.), James Grant Miller (Z., P.), Ramsay Millar (Z., P.), Hugh Miller (P.), Norman Macleod Miller (Z., P.), Alexander MacCulloch (B., C.), James Hogg MacDonald (Z., P.), Archibald Turner Macewan (P., C.), Peter MacIntosh M'Fadyen (Z., P.), John M'Gilchrist (Z., P.), David Duncan Fraser Macintyre (B., P.), Charles Forbes Maclean (Z., P.), Norman Forbes MacLeod (Z., P.), William Johnston Maclure (B., P.), Alfred Robert Maclurkin (Z., C.), John M'Millan (B., P.), Roderick Reid Macnicol, M.A. (C.), Thomas Neill (B., P.), John Patton (B., Z., C.), Thomas Stephens Picken (Z., P.), William Barr Inglis Pollock B., P.), Arthur Robin (Z., P.), James Scott, M.A. (Z., C.), John Shaw, M.A. (Z., C.), James Shearer (B., Z., P., C.), Andrew James Smith (Z., P.), David James Smith (Z., P.), James Smith (P., C.), James Johnston Smith (B., C.), William Stewart Stalker (P., C.), Alfred George Stewart (Z., C.), Frederick Richardson Stewart (B., C.), James Douglas Brownlee Stewart (B., C.), Peter Donald Strachan, M.A. (B., C.), James Alexander Sutherland (B., P.), Charles Pinkerton Thomson (Z.), William Brown Thomson (B., P.), Thomas Bird Tierney (P., C.), Alexander Laurie Watson, M.A. (Z., P.), Alexander Simpson Wells (Z., C.), Robert Orr Whyte (B., Z., P., C.), George Henry Wildish (Z., P.), Morgan Watkin Williams (P.), Alexander Wilson (Z., P.), William Wright (Z., P.), and John Doctor Young (Z., C.).

Women candidates.—Sarah Davidson (P., C.), Marjorie King Henderson Fleming (P., C.), Jessie Downie Granger (P., C.), Mabel Hardie (P., C.), Jessie Sophia Beatrix Hunter (P., C.), Mary Longmire (B., P.), Jane Lorimer (C.), Annie Louise M'Ilroy (B., C.), Ina Lochhead M'Neill (P., C.), Mary Lauchline M'Neill (Z., P.), Sara Maude Robertson (P., C.), Maud Spencer (P., C.), Gertrude Florence Fleetwood Taylor (P.), and Grace Lorrain Young (P., C.).

The following have passed the Second Professional Examination (old regulations) for the degrees of Bachelor of Medicine (M.B.) and Master in Surgery (C.M.):—

William Buchan Armstrong, John Tait Bowie, John Ritchie Burns, James Banks Cumming, John James Edgar, George Louis Le Fevre, Robert Hugh Meikle, John Allan Craigie Macewen, William Fullerton M'Ewen, Archibald M'Glashan, Lionel Mitchell Mackay, William M'Mullen Pearson, James Hood Rankin, James Rutherfurd Ratcliffe, Robert Shanks, Joseph Sillars, Archibald Stevenson, and David Lyon Stevenson, M.A.

The following have passed the Second Professional Examination (new regulations) for the degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.) in the subject or subjects indicated after their respective names (A., Anatomy; P., Physiology; M.M. and T., Materia Medica and Therapeutics):—

Alexander Smith Allan (A., P.), Theodore Belchambers Broadway (A., P.), David Louis Cairns (A., P.), Francis James Charteris (A., P.), Joseph Adam Clarke (A., P.), George William Coats (A., P.), James Duncan Cochran (A., P.), Walter Scobie Findlay, M.A. (A. P.), James Finlayson Fleming (A., P.), Adrian Andrew Forrester (A., P.), Lawrence Whitaker Harrison (A., P., M.M. and T.), Alexander Lawrie (A.), William Mitchell Lindsay (A., P., M.M. and T.), William Glen Liston (A., P., M.M. and T.), John MacDonald (A., P.), James M'Haffie (A., P.), David M'Kail (A., P.), James M'Queen, M.A.

(A., P.), Normal Emil Henry Scott (A., P.), Alexander Bankier Sloan (A., P.), Samuel Macfarlane Sloan (A., P.), David Steele Smith (A., P.), James Strang (A., P.), Matthew Logan Taylor (A., P.), Walter Lewis Thomson (A., P.), William Watson (A., P.), Ernest Watt (A., P.), Edward Roberts Weir (A., P.), William Wyper (A., P.), and David John Young (A., P.).

Women candidates.—Daisy Annabella Murdoch Clark (A., P.), Margaret Elizabeth M'Neill (A., P.), and Jessie Hawkesworth Smith (A., P.).

The following have passed the third professional examination for the degrees of Bachelor of Medicine (M B) and Master in Surgery (C.M.):—

A., including Pathology.—John Allan, Samuel Anderson, B.Sc., John Ritchie Brown, William Burns, Malcolm Campbell, John Divine, Matthew Dunning, Thomas M'Gibbin Fletcher, Daniel M'Intyre Glen, George Hanson, Allen Iredale, John William Jackson, John Knight, John Walker Munro, William Milroy M'Farlane, John Souttar M'Kendrick, Hugh M'Laren, John M'Laws, Thomas Duncan Newbigging, Harry Couper Patrick, David Shedden Service, James Craik Taylor, Noel Charles Echlaz Ward, Henry Whitehouse, and James Eric Wilson.

Women candidates.—Mary Baird Hannay and Madge Speirs Maclean.

B., not including Pathology.—Alfred Charlton, Duncan Drummond, George Henry Beck Harvie, Robert Hastie, James Hogg, Edwin Brooke Jago, John Marshall, Samuel Martyn, John Robert Gordon Phillips, James Malloch Robertson, Neil Robson, Wm. Kerr Russell, and Ernest Fred. Docetti Walker.

ROYAL COLLEGE OF SURGEONS IN IRELAND.—SCHOOLS OF SURGERY.—Class prizes winter session, 1894-95. Descriptive Anatomy: Junior, W. J. Anglim, first; H. M. Clarke and J. M. Crawford (equal), second; senior, F. J. Palmer, first, and R. H. D. Pope, second. Practical Anatomy: First year, S. R. Godkin, first, and J. J. Huston, second; second year, M. W. Falkner, first, D. Hadden and J. Leventon (equal), second; third year, A. S. Greene, first, and A. McMunn, second. Practice of Medicine: D. Kennedy, first, and W. M. Power, second. Theoretical Surgery: A. I. Eades, first, and D. Kennedy, second. Midwifery: G. A. Robinson, first, and J. A. McMunn, second. Physiology: F. J. Palmer, first, and D. Hadden, second. Chemistry: W. J. Anglim, first, and S. R. Godkin, second. Pathology: G. A. Robinson, first. Physics: W. J. Anglim and D. A. Fitzgerald (equal), first, and M. Gavin, second. The schools opened on Monday, April 1st, for the three months' courses of Operative Surgery, Practical Chemistry, Pharmacy, Public Health, Forensic Medicine, Materia Medica, Histology, Biology, and Dissections.

SOCIETY FOR THE PREVENTION OF HYDROPHOBIA AND REFORM OF THE DOG LAWS.—A meeting of the General Committee of the Society for the Prevention of Hydrophobia was held on the 8th inst. at 25, Cavendish-square, W., Professor Victor Horsley, F.R.S., in the chair. In the chairman's report reference was made to the communications which had passed between the Board of Agriculture and the society's executive on the subject of the Dogs Bill, and also to the prevailing epidemic of rabies and hydrophobia in Yorkshire, Lancashire, and other northern counties and in Ireland. It was pointed out that but for political considerations the policy advocated by the society and endorsed by the highest medical authorities, as well as by many of the most important dog-breeders and dog-owners throughout the country, would doubtless be carried into effect by the Government of the day. It would only be when the pressure of these combined forces of instructed and responsible opinion became too great for any Government safely to resist that the object for which the society was formed would be accomplished. This object, it was needless to say, was the total extinction of rabies and hydrophobia from the United Kingdom by a system of universal muzzling for at least twelve months, coupled with rigid and permanent quarantine. The attitude of the general public, except during the scare created by an epidemic of rabies, was one of apathy and indifference. It was useless therefore to expect the assistance which many causes derive from a public movement or demonstration in their favour. The aims the society had in view would therefore be best promoted by securing the increased adherence of members of the medical profession and men of influence generally (especially of those recognised as leaders of opinion in canine matters), so that when the proper moment arrived the society would have sufficient support behind it to convince any Government that the subject was not a question of party politics, but of public welfare. Since the last meeting of the committee liberal contributions to the funds of the society have been received from the Duke of Northumberland (president of the society), the Duke of Westminster, the Earl of Coventry, Sir Joseph Lister, Bart., Sir James Whitehead, Bart., and many others.

PUBLIC BATHS IN SOUTHWARK.—The vestry of the parish of St. Saviour, Southwark, have erected public baths and wash-houses in Lavington-street, at a cost of £40,000, inclusive of £10 000 for the site. There are two swimming baths, the first-class, which is 120 ft. long by 48 ft. wide, and the second-class, which is rather smaller. There are also first and second-class private baths, and in the wash-houses separate compartments are provided for twenty-four workers. The formal opening took place on April 6th, in presence of a large company.

NORTH RIDING INFIRMARY, MIDDLESBROUGH.—The annual meeting of this hospital was held on April 4th, Alderman J. F. Wilson, J.P., presiding. The report showed that there had been a considerable increase in the number of in-patients, and that the expenditure had exceeded the income by £108. Adding the deficiency brought forward from the previous year, the total indebtedness is £252, for the diminution of which special efforts are being made by public appeals and by an exhibition to be held in the town hall in the autumn. There is great need for a new operating room, the estimated cost of which is £900.

CIVIL RIGHTS DEFENCE COMMITTEE (PRESIDENT, THE RIGHT HON. THE EARL OF STAMFORD).—The Committee append a further list of subscribers to the Anderson Privy Council Appeal Fund. At the meeting of the Committee on March 15th, 1895, the following resolution, moved by General Graham and seconded by Mr. Foulerton, was unanimously adopted: "That the thanks of the Civil Rights Defence Committee are due and are hereby tendered to Dr. Branch and the members of the Leewards Branch of the British Medical Association for their generous and practically unanimous support to this committee in the defence of the civil rights involved in Mr. Anderson's case and for their support and sympathy with Mr. Anderson in his arduous and protracted struggle for the defence of these rights. That such support, coming from the West Indies, where the attack upon those rights occurred, is of special value, and is especially appreciated by the committee." Additional subscribers to the Anderson Privy Council Appeal Fund to March 31st, 1895:—

Anonymous sympathiser, per Mr. A. M. Lee			£1 1 0
Dr. Dukes, Rugby, as per list—			
Mr. T. Duke, M.A., Rugby	£0	5 0	
Mr. Sutton Pratt, Rugby	0	5 0	
Mr. Bernard Relton, Rugby	0	5 0	
Mr. W. A. E. Waller, Rugby	0	5 0	
Dr. J. H. Simpson, Rugby	0	10 6	
			1 10 6
Mr. W. G. Groves, Woodford Green			0 5 0
Members of the Leeward Islands Branch of the British Medical Association (collected by Dr. W. J. Branch, St. Kitts)—			
Mr. J. D. Bell, Nevis	0	10 0	
Dr. W. J. Branch, St. Kitts	1	1 4	
Dr. J. H. Cooke, Nevis	0	10 0	
Mr. M. P. Duke, Montserrat	0	10 6	
Mr. A. E. Edwards, Antigua	0	10 6	
Mr. W. H. Edwards, Antigua	1	1 0	
Mr. J. Foreman, St. Kitts	0	10 6	
Dr. F. J. Freeland, Antigua	0	10 6	
Mr. W. H. Fretz, St. Kitts	1	0 10	
Mr. J. S. Gabriel, Antigua	0	10 6	
Dr. P. J. Huggins, Nevis	0	10 0	
Dr. G. H. Mapleton, St. Kitts	1	0 10	
Dr. H. A. Nicholls, Dominica	1	1 0	
Dr. F. L. Norris, Montserrat	0	10 6	
Mr. J. N. Rat, St. Kitts	0	10 6	
Mr. R. E. Semper, St. Kitts	0	10 6	
Mr. A. L. Wykeham, Antigua	1	1 0	
			12 0 0

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LITERARY INTELLIGENCE.—Mr. Lewis will issue immediately in his "Practical Series" a new volume on Surgical Diseases of Children, by Mr. D'Arcy Power, M.A., M.B. Oxon., F.R.C.S. Eng.

THE METROPOLITAN HOSPITAL.—The annual meeting of this hospital was held on April 8th on the premises in Kingsland-road, Mr. Joseph Fry presiding. The report showed that 781 in-patients were admitted during 1894, and that there were 73,000 attendances of out-patients. Special arrangements have been made for the attendance of Jewish out-patients on two days of the week, and two wards have been set apart for Jewish in-patients, providing beds for seven men and five women. The hospital dinner will be held on June 13th, and Mr. Leopold de Rothschild has promised to preside.

COOKERY AND FOOD EXHIBITION.—His Serene Highness General Prince Edward of Saxe-Weimar, K.C.B., has consented to open the Eighth Universal Cookery and Food Exhibition to be held at the Portman Rooms on May 7th. The soldier cooks of the Grenadier, Coldstream, and Scots Guards will be allowed, by special permission of the Commander-in-Chief, to take part in the competitions, and the Army School of Cookery, Aldershot, by permission of the general officer commanding, will demonstrate the methods of cooking army rations.

FOOTBALL CASUALTIES.—On the 28th ult., during a match at Brentford between the Brentford Early Closing Association and the North London Wanderers Clubs, one of the visiting team fractured his leg and was taken to the Brentford Cottage Hospital.—On Saturday last the captain of the Scarborough Ebor (Association) Club, while playing for his club, sustained a fracture of his left leg.—On the same day a young man aged twenty-two years, in a match between the Radford and Carrington Evening Continuation School teams, fractured his leg and was admitted to the Nottingham General Hospital.

CAMBRIDGE UNIVERSITY.—The following gentlemen have passed the University examination qualifying them for the functions of medical officer of health: William George Armstrong, Martin Ashley, M.B., Frank George Bushnell, M.D., Charles Buttar, M.B., B.S., Allan Gordon Russell Cameron, M.B., B.S., Edgar Godfrey Carpenter, John William Henry Eyre, M.B., B.S., Andrew Mearns Fraser, M.B., M.S., John William Frank Jewell, M.B., B.S., Harold Jossé Johnson, M.B., Harry Angell Lane, John Henry M'Gee, James Stevenson Morton, M.B., B.S., George Percy Shuter, M.B., B.S., and William James Johnstone Stewart, M.B., M.S.

ILKLEY HOSPITAL AND CONVALESCENT HOME.—The annual meeting of this institution, which has now been in existence for sixty-six years, was held at the hospital on April 3rd, Mr. A. Harris presiding. Patients are not ordinarily received all the year round; and the annual report stated that last season the hospital was open for thirty-two weeks, the number of patients being 1018. Dr. Johnstone, the medical officer, reported that of these there were 955 who were either cured or materially benefited. The invested capital approaches £8000, but last year's expenditure exceeded the income by £168, and increased subscriptions are urgently needed.

MEDICO-PSYCHOLOGICAL ASSOCIATION.—A well attended meeting of the South-Western Division was held at the City Asylum, Bristol, on Thursday, April 4th. Dr. Nicolson was in the chair. On the motion of the Chairman, seconded by the Hon. Secretary, a vote of condolence with Mrs. Tuke and family was adopted. It was decided to hold the next meeting on Tuesday, Oct. 15th, at Exeter. Dr. Hubert Bristowe and Dr. Blackford read interesting and valuable papers. Dr. Law Wade's motion on the question of granting gratuities to the widows or orphans of asylum officials who may die after long service or be injured fatally in the discharge of their duties was unanimously agreed to, and the Hon. Secretary was instructed to forward copies of the resolution to the council of the association, also to the medical superintendents of public asylums and hospitals in the division. Owing to the lateness of the hour Dr. MacDonald's paper on the Nursing Staff was postponed till the next meeting. There were several visitors present, and the members and visitors afterwards dined at the Grand Hotel.

MEDICAL MAGISTRATE.—On the recommendation of the Duke of Westminster, Lord Lieutenant of the county, the Lord Chancellor has placed Mr. George Okell, M.R.C.S., Surgeon-Lieutenant-Colonel 3rd V.B. Cheshire Regiment, on the Commission of the Peace for the county of Chester.

MUNIFICENT GIFT.—According to the *Times* Mr. Henry Harben of Hampstead, who has taken great interest in the North-West London Convalescent Homes Fund for Working Men, has decided to erect at his own expense a building at Littlehampton to cost £20 000. The home will contain reading-rooms, &c., and all the latest improvements, and will be lighted throughout by electricity. The work will be put in hand forthwith.

PRESENTATIONS.—Dr. Francis T. Richardson, of Rothbury, Morpeth, was entertained by his friends on the 2nd inst. at a complimentary banquet at the Queen's Head Hotel, on his leaving the district to take up his residence in Edinburgh, and was presented at the same time, as a mark of their respect, with a small souvenir in the shape of a pair of gold-rimmed eye-glasses and a gold-headed cane. The chairman, Mr. W. Forster, of Burradon, in making the presentation on behalf of the subscribers, expressed the general regret felt at Dr. Richardson's departure from amongst them, after half a century's residence. The articles offered for his acceptance were not of great intrinsic value, but he knew they would be prized none the less on that account.—On March 30th Mr. J. Kay Tomory, M.B., of Halkirk, was presented by his patients with a purse of sovereigns accompanied by a request that the sum contributed should be devoted to the purchase of a horse and riding outfit. The value of the gift is enhanced by the fact that it consisted largely of small amounts given by the working classes in the district.

THE DANGERS OF ELECTRIC MAINS.—The committee of the members of the Royal Society and the Institution of Electric Engineers appointed to confer with the electrical adviser to the Board of Trade with regard to the circumstances connected with the formation in large quantity of an alkaline deposit in the mains of the St. Pancras electric supply and the presence in this deposit, in some cases, of sodium or potassium, have, it is announced by the *Times*, issued their report. It has already been proved that sparks may be caused by the incrustation itself, and now it appears that the metals just mentioned have been found to exist in the free state in the incrustation, and that they are probably produced from the electrolytic decomposition of alkaline salts, chiefly derived from the soil and conveyed by moisture along the fibres of the wooden bearers towards the negative conductors. It is accordingly recommended that these bearers should be replaced by devices impervious to moisture, and a longer insulating surface between the conductors and the bearers is advised. Steps should also be taken so that the conduits may be inspected throughout their length. Coal gas is, however, regarded as the primary source of danger. The report is signed by Major Cardew, Lord Rayleigh, Professor T. E. Thorpe, Professor Crookes, Mr. R. E. Crompton, Mr. Alexander Siemens, and Mr. Alex. B. W. Kennedy.

Parliamentary Intelligence.

NOTES ON CURRENT TOPICS.

Undersized Flat Fish.

THE Government have introduced a Bill making it illegal for any person to "import, export, buy, sell, expose for sale, consign for sale, or have in his possession for sale," a sole or plaice not exceeding eight inches in length, or a turbot or brill not exceeding ten inches in length. The Bill confers on officers of Customs, Board of Trade, fishery committees, and other public bodies ample powers of search and detention.

Reforms in Egypt.

Lord Cromer has made to the Foreign Office another report on the finances, administration, and condition of Egypt and the progress of reforms in that country. In a section devoted to the sanitary department his lordship says that under the intelligent direction of Rogers Pasha much progress has been made. New dispensaries have been opened. The number of patients treated in Government hospitals has increased. An infectious diseases hospital at Cairo has been completed. An English physician is about to be placed in charge of the lunatic asylum. Three new hospitals at Damanhour, Fayoum, and Beni Souef are in course of construction. Slaughter-houses are being built in

several provincial towns. A vaccine institute has been completed. Sixty-six mosques have been placed in a sanitary condition, and 121 cemeteries have been dealt with under the Sanitary Decree passed in January, 1894. Lord Cromer quotes Rogers Pasha to this effect—viz., "It is an undoubted fact that the population is gradually beginning to appreciate the advantages of medical institutions, whether hospitals or dispensaries. Demands are now constantly made for the creation of new dispensaries and hospitals throughout the country, and it is a matter of the deepest regret that the resources of the department should be so limited as to prevent these demands being complied with." In his concluding sentence Lord Cromer expresses the hope that some portion of the general reserve fund may eventually be devoted to sanitary improvements.

HOUSE OF COMMONS.

THURSDAY, APRIL 4TH.

The Tuberculosis Commission.

Mr. Shaw-Lefevre, President of the Local Government Board, replying to a question put by Lord Wolmer, said he must disclaim any personal responsibility for the delay in the issue of the report of the Royal Commission on Tuberculosis, which was largely due to the long illness and death of the chairman, Lord Basing. There had been no delay since the appointment of a new chairman, and he believed that the report was signed on the previous day. A supplementary report by one of the Commissioners was now being printed, and it was expected that this would be signed shortly, and both reports would then be presented.

Factory and Workshop Legislation.

Mr. Asquith, Home Secretary, in replying to a question on this subject by Sir Charles Dilke, said that to extend the interpretation of the term "workshop" so as to include a warehouse not connected with a factory or workshop, where the work carried on was mere packing or bottling, and not in any sense the making or adapting for sale of the article, would be a very great extension of the Factory Acts, and would bring within their operation the establishments of most wholesale grocers, chemists, and drapers. Many of the provisions of the Acts were not really appropriate to the work carried on in these places, and the duty of inspecting them would necessitate a very large increase in the present staff. He must not be understood as holding that warehouses of this kind might not properly be made the subject of statutory regulation; but he thought that if they were to be dealt with, as in the case of shops, there should be special legislation on the subject.

New Legislation for Coal Mines.

Mr. Asquith, on behalf of the Government, introduced a Bill to amend the Coal Mines Regulation Act of 1887. In doing so he explained that the Bill proposes in effect to carry out the recommendations of the Royal Commission with regard to the making of special rules as to explosives and so forth in mines which are dangerous from the presence either of coal damp or coal dust, and makes one or two changes which experience has shown to be necessary with regard to deductions made in the wages of the miners in respect of the presence of foreign materials in coal they turn out.

FRIDAY, APRIL 5TH.

Female Labour in Factories.

Sir Charles Dilke asked the Home Secretary whether, in their recent visits to textile factories for the purpose of making inquiry as to the opinion and wishes of the women workers with regard to overtime, the inspectors had seen the women in the presence of their employers. Mr. Asquith replied that an isolated case appeared to have occurred in which the opinion of the operatives was asked in the presence of the employers, but this was entirely contrary to the usual practice of the factory inspectors, and instructions had been issued which would prevent its recurrence. It was clear that when operatives were questioned in the presence of their employers the inspector might fail entirely to ascertain their real opinions and wishes.

MONDAY, APRIL 8TH.

The Accommodation for Ships' Crews.

Mr. Bryce, President of the Board of Trade, said, in the course of a reply to Mr. Havelock Wilson, that such steps as his department were able to take without fresh legislation with regard to the recommendations of the Royal Commission on Labour affecting Seamen had already been taken, and the question of increasing the minimum crew space allowance would be considered when an opportunity for legislation occurred. All British merchant vessels were required to have for each seaman or apprentice a space of not less than 72 cubic feet, and penalties were provided for contravention of this requirement. Complaints had, however, recently been made to the Board of Trade that in certain vessels carrying Lascar seamen only the space (36 cubic feet for each man) required by the Indian Act had been provided. The owners of these vessels had been informed that the provisions of the Imperial Act must be complied with, and the matter was receiving the careful attention of the Board of Trade surveyors. Representations had also been made to the Secretary of State for India.

Guardians and Infirmary Visitation.

Mr. Macdona addressed a question to the President of the Local Government Board with reference to a visit recently paid by two guardians at a late hour of the evening to the infirmary of the St. Olave's Union, Southwark, and the complaint made by the medical officer on the subject. Mr. Shaw Lefevre, in his reply, said his attention had been called to the matter, and he found the facts were substantially as the hon. member had stated them. The Local Government Board had not thought it expedient to fix the hours during which a guardian might visit the workhouse or infirmary; but they had expressed a decided opinion that the case would be a very exceptional one in which it would be proper that a guardian should pay such a visit late at night, and that to justify his doing so there ought to be strong *primâ-facie* grounds for believing that special and unusual circumstances rendered the visit necessary. The Board had also stated that a visit late at night ought not to be paid to a sick ward, unless it had been previously ascertained from the medical officer that it would not be detrimental to any of the sick occupants of the ward.

TUESDAY, APRIL 9TH.

Quarantine.

Mr. Shaw-Lefevre, answering a question put by Sir Francis Powell, said that a Bill was in preparation on the subject of quarantine, but as there were many interests concerned he was unable to say when it would be introduced.

The Ventilation of School Buildings.

Sir Francis Powell called the attention of the Vice-President of the Committee of Council on Education to the provisions in the new code for ventilation by enlarged inlets and outlets, in addition to the windows, and asked whether they were not likely to lead to inconvenience and danger to health. Mr. Acland, in reply, said that the size of the ventilators proposed was not unduly large. The teachers, he added, would of course exercise a discretion in opening and shutting windows. It was hoped that the provision would be beneficial and not injurious to the health of the children.

IN COMMITTEE.

Food Products Adulteration.

The Select Committee of the House of Commons on this subject held another meeting on Tuesday, April 9th, with Sir Walter Foster in the chair.

Mr. James Hamilton, President of the Glasgow Provision Trade Association, examined by the chairman, said that the butters mainly sold in Scotland, apart from home products, came from Denmark and the colonies, and were of good quality; indeed, he thought there was not a large quantity of adulterated butter of any kind sold in Scotland. As to the presence of water in butter, he did not think it would be safe to fix a legal standard, because in its application it would affect injuriously many men honestly engaged in the making of butter, and, moreover, would lead to a general deterioration in the quality of the butter put upon the market. A very large quantity of margarine was sold in Scotland, but very little of it was sold fraudulently. In experience, it was found that the people who strictly conformed to the provisions of the Margarine Act were the people who sold most margarine in Scotland. He had to complain that the Act was not enforced with sufficient stringency, and he recommended that the Government should appoint and pay special inspectors to see to this matter. Margarine he regarded as a good, useful, and suitable article of food, and he would do nothing to interfere with its legitimate sale. He would not have licences for dealers in margarine nor would he prohibit mixtures or the colouring of margarine. Indeed, all he desired was to see the existing law properly enforced.

Mr. Van den Bergh, member of a firm of margarine makers in Holland and Germany, said he was appointed by the London Chamber of Commerce to give evidence on the sale of margarine. Last year his firm turned out 66,000,000 lb. of margarine, all of which was shipped and branded as margarine. In their factories they used from 80,000 to 100,000 lb. of milk per day. He admitted that the colour of margarine as sold resembled very closely that of butter, but it was coloured not to imitate butter, but to make it attractive. If not coloured, margarine would not be appreciated by the public even if sold at a cheap price, and he believed that any interference with the present system of colouring would be disastrous to the margarine trade. He failed to see why margarine should be singled out and coloured pink or blue. He was not in favour of having margarine sold in separate shops. On the whole, he considered that if the present Act were stringently enforced it would be quite sufficient to protect the public. The fines now imposed were quite heavy enough, for upon a third offence no less a fine than £100 could be imposed. He was in favour of travelling inspectors being appointed and of the Customs authorities being compelled to take samples of produce that came into the country unmarked. He should like to see mixtures sold as such, and not, as they were at present, as margarine.

Mr. McCallum, a member of a London firm of butter and margarine importers, who attended at the request of the London Chamber of Commerce, expressed the opinion that the wholesale houses dealt in a perfectly honest fashion with margarine, and the fraud took place after the article left them. He also denied that margarine was coloured in order to make it resemble butter, and he thought that mixtures should be allowed in the interests of the public.

The Committee then adjourned, not to meet again until after the Easter recess.

BOOKS ETC. RECEIVED.

ALCAN, FÉLIX, Boulevard Saint-Germain, Paris.

Huitième Congrès de Chirurgie, Lyon, 1894-95. pp. 903.

APPLETON, D., & Co., New York.

Transactions of the Sixteenth Annual Meeting of the American Laryngological Association, held in Washington, May and June, 1894. pp. 181.

BAILLIÈRE, TINDALL, & COX, King William-street, Strand, London, W.C.

Our Teeth: Care and Preservation. By V. Ditcham, M.D., D.D.S., L.D.S. 1895. pp. 52. Price 1*s.*

BAILLIÈRE, TINDALL, & COX, AND F. WARNE & Co., London.

The Spirit of Cookery: a Popular Treatise on the History, Science, Practice, and Ethical and Medical Import of Culinary Art, with a Dictionary of Culinary Terms. By J. L. W. Thudichum, M.D., F.R.C.P. Lond. 1895. pp. 701. Price 6*s.*

BALE, JOHN, & SONS, Great Titchfield-street, Oxford-street, London.

An Inquiry into the Etiology of Rötheln (German measles). By Donald W. C. Hood, M.D. Cantab., F.R.C.P. Lond. 1895. pp. 55.

CALCUTTA CENTRAL PRESS COMPANY, Calcutta.

A Medico-Topographical Account of Jeypore. By Brigade-Surgeon Lieutenant-Colonel T. Holbein Hendley, C.I. . 1895. pp. 128.

CHURCHILL, J. & A., New Burlington-street, London.

The Schott Methods of the Treatment of Chronic Diseases of the Heart. By W. Bezley Thorne, M.D., M.R.C.P. Illustrated. 1895. pp. 79. Price 5s.

Surgery: Its Theory and Practice. By William J. Walsham, M.B., C.M. Aberd., F.R.C.S. Eng. Illustrated. Fifth Edition. 1895. pp. 786. Price 12s. 6d.

The Treatment and Education of Mentally Feeble Children. By Fletcher Beach, M.B., F.R.C.P. Lond. 1895. pp. 32. Price 1s. 6d.

COX, HORACE, Bream's-buildings, Chancery-lane, London, E.C.

Horses, Asses, Zebras, Mules, and Mule Breeding. By W. B. Tegetmeier, M.B.O.U., F.Z.S.; and C. L. Sutherland, F.Z.S. 1895. pp. 166. Price 5s. net.

ENGELMANN, WILHELM, Leipzig.

Lehrbuch der vergleicheuden Pathologie und Therapie. Von Dr. G. Schneidemühl. Erste Lieferung. 1895. pp. 208.

FUNK & WAGNALLS COMPANY, Fleet-street, London, and New York.

A Standard Dictionary of the English Language, upon original plans, under the supervision of J. K. Funk, D.D., Editor-in-Chief. Vol. ii., M to Z. 1895.

LEWIS, H. K., Gower-street, London, W.C.

A Manual of Gynæcological Practice for Students and Practitioners. By Dr. A. Dührssen. Translated and edited from the Fourth German Edition by J. W. Taylor, F.R.C.S., and Fred. Edge, M.D. Lond., M.R.C.P., F.R.C.S. Illustrated. 1895. pp. 241. Price 6s.

LONGMANS, GREEN, & Co., London.

A Primer of Evolution. By Edward Clodd. Illustrated. 1895. pp. 186. Price 1s. 6d.

LYONS, JAMES B., State Printer, Albany.

Eighth Annual Report of the Managers of the St. Lawrence State Hospital for the Year 1894. 1895. pp. 210.

MACMILLAN & Co., London.

The Cambridge Natural History. Edited by S. F. Harmer and A. E. Shipley. Vol. iii.—Mollusca, by the Rev. A. H. Cooke; Brachiopods (recent), by A. E. Stanley; Brachiopods (Fossil), by F. R. C. Reed. 1895. pp. 535. Price 17s. net.

MASSON, G., Boulevard Saint-Germain, Paris.

La Voix modifiée par les Inhalations. Par Dr. A. Sandras. 1894. pp. 107.

PARTRIDGE, S. W. & Co., Paternoster-row, London.

Benjamin Townson: a Record of a Doctor's Life and Work. By his Daughter. pp. 168. Price 2s.

PENTLAND, YOUNG J., Edinburgh and London.

Outlines of Zoology. By J. Arthur Thomson. M.A., F.R.S.E. Second Edition. Illustrated. 1895. pp. 820.

Atlas of the Diseases of the Skin. Illustrated. By H. R. Crocker, M.D., F.R.C.P. Fasciculus 9. Price 21s. net.

SEGG, J. P., & Co., Regent-street, London.

General Surgery and Pathology for Dentists. By Edmund W. Roughton, B.S., M.D. Lond., F.R.C.S. Illustrated. 1895. pp. 134.

SLEVIN, E. P., Barclay-street, New York.

Edwards' Hygiene, with Anatomy and Physiology, being an amplification of Edwards' Catechism of Hygiene. By Jos. E. Edwards, A.M., M.D. pp. 435.

STEINHEIL, G., Paris.

Cystite et Infection Urinaire. Par Dr. Max Melchior. 1895. pp. 385.

Chirurgie du Rectum. Par E. Quénu et H. Hartmann. 1895.

Chirurgie de l'Urèthre, de la Vessie, de la Prostate. Par V. Rochet. 1895. pp. 286.

URBAN & SCHWARZENBERG, Wien und Leipzig.

Pathologie und Therapie der angebornen Hüftverrenkung. Von Professor Dr. A. Lorenz. 1895. pp. 420.

A Study of Erysipelas: by J. Selva, M.D.; reprint from the *New York Medical Journal*: 1894.—Société des Ambulances Urbaines de Bordeaux; Compte-Rendu No. 3; année 1893 (G. Gounouilhou, Bordeaux, 1894).—Ueber den derzeitigen Stand der Bestrebungen einer Serumtherapie der Syphilis, nebst praktischen Vorschlägen zu einer solchen; von Dr. E. Spiegler (L. Bergmann & Co., Wien, 1895).—The Natural History of Plants, Part 12 (Blackie & Son, London); price 2s. 6d. net.—Willing's British and Irish Press Guide, 1895 (J. Willing, 162, Piccadilly); price 1s.—Magazines for April: Strand Magazine, Picture Magazine, London Home.

Appointments.

Successful applicants for Vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column, are invited to forward it to THE LANCET *Office, directed to the Sub-Editor, not later than 9 o'clock on the Thursday morning of each week, for publication in the next number.*

BARROW, GEORGE A., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Junior House Surgeon to the Bolton Infirmary for twelve months.

BEVAN, RICHARD, L.R.C.P. Lond., M.R.C.S., D.P.H. Eng., has been reappointed Medical Officer of Health for the Lydd Urban Sanitary District.

BRIGGS, WM. P., L.R.C.P., L.M., L.F.P.S. Glasg., has been reappointed Medical Officer of Health for the Wigton Rural Sanitary District.

BUCHANAN, GEORGE S., M.D., B.Sc. Lond., has been appointed Medical Inspector to the Local Government Board.

BUIST, A., M.D., F.R.C.S. Edin., has been appointed Parochial Medical Officer for Dunblane, vice Brown.

BURDWOOD, JAS. W., L.F.P.S., L.M. Glasg., has been reappointed Medical Officer of Health for the Bourne Rural Sanitary District.

CLEGG, WALTER, M.R.C.S., has been appointed Medical Officer of Health to the Boston Rural District Council.

COLBY, J. G. E., M.B., B.Ch. Oxon., L.R.C.P. Lond., F.R.C.S., D.P.H. Camb., has been appointed Medical Officer of Health for the Malton Rural Sanitary District and the Norton Rural Sanitary District.

COOPER, C. E., M.B., B.C. Cantab., has been appointed House Physician to the City of London Hospital for Diseases of the Chest, Victoria-park.

DAVIES, W. T., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Western Sanitary District of the Llandilofawr Union.

DICKIN, E. P., M.B., C.M. Edin., has been appointed Assistant House Surgeon to the General Infirmary, Northampton.

DREAPER, J. B., L.R.C.P., L.M. Edin., M.R.C.S., has been appointed Medical Officer of Health to the Ashbourne Rural District Council.

DUNLOP, ROBERT S., M.B., C.M. Edin., has been appointed Medical Officer to the Parish of Dalmellington and to the Dalmellington Iron Company, vice R. Maclachlan, deceased.

EDMONDSON, C. R., M.B., C.M. Edin., has been appointed Senior House Surgeon to the Royal Southern Hospital, Liverpool.

EVANS, A. L., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Buckley Sanitary District.

FLEMMING, C. E. S., M.R.C.S., has been reappointed Medical Officer for the Eighth Sanitary District of the Bath Union.

FLOWER, FRED. J., M.R.C.S., L.M., has been appointed Medical Officer of Health to the Warminster Rural District Council.

GANGE, F. W., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health to the Faversham Rural District Council.

GILBEE, L., M.R.C.S., L.R.C.P. Lond., has been appointed Second Assistant Medical Officer to the St. Marylebone Infirmary, vice R. J. Smythe, resigned.

GUNN, F. W., M.D., B.S. Durh., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Fourth Sanitary District of the Morpeth Union, vice Forrest, resigned.

HARPER, T. E., L.R.C.P. Lond., has been appointed a Junior Assistant Medical Officer of Holloway Sanatorium Hospital for the Insane, Virginia Water.

HAWORTH, F. G., M.B., C.M. Glasg., L.R.C.S. Edin., D.P.H. Camb., has been appointed Medical Officer of Health to the Darwen Urban Sanitary Authority.

HOLLIS, H., B.A., M.B., B.C. Cantab., has been appointed House Surgeon to the General Infirmary, Northampton.

KEMPE, CHAS. M., M.R.C.S., has been appointed Medical Officer of Health to the Shoreham Urban District Council.

LENTAIGNE, JOHN, F.R.C.S.I., has been appointed Visiting Surgeon to the Children's Hospital, Dublin.

MACKINTOSH, ANGUS, M.D. Glasg., L.F.P.S., L.M., has been appointed Medical Officer to the Clay Cross District Council.

MARSH, JAMES, M.B., C.M. Edin., has been appointed Second House Surgeon to the Royal Southern Hospital, Liverpool.

NUTHALL, R. L. S., L.R.C.P. Lond., has been appointed Assistant Medical Officer, with charge of the Male side, of Holloway Sanatorium Hospital for the Insane, Virginia Water.

OSWALD, LANDELL ROSE, M.B., has been appointed Medical Superintendent of the City of Glasgow Asylum, at Gartloch.

PARKINSON, J. PORTER, M.D., M.R.C.P. Lond., F.R.C.S. Eng., has been appointed Medical Registrar to the Westminster Hospital.

POLAND, JOHN, F.R.C.S. Eng., has been appointed Surgeon to the City Orthopædic Hospital, vice E. T. Chance, deceased.

RICHARDSON, RICHARD T., M.R.C.S., has been reappointed Medical Officer of Health for Trowbridge.

ROBERTS, E. R., L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., has been appointed Medical Officer for the Hawarden Sanitary District.

ROBERTSON, JOHN, M.D., L.R.C.S., L.M. Edin., has been appointed Medical Officer of Health to the Cockermouth Urban District Council.

RODEN, PERCY A., M.B., C.M. Aberd., has been reappointed Medical Officer of Health to the Droitwich Town Council.

SANDERSON, J. A., L.R.C.P. & S. Edin., has been appointed Junior House Surgeon to the Royal Southern Hospital, Liverpool.

STAUNTON, M. C., M.D., B.Ch., has been appointed Visiting Surgeon to the Children's Hospital, Dublin.

THORNE, J. M., L.R.C.P. Lond., M.R.C.S., has been appointed Consulting Surgeon to the Retford Cottage Hospital.

WARE, JOHN W. L., L.R.C.P. Lond., M.R.C.S., has been reappointed Medical Officer of Health for the Fourth Sanitary District of the Barnstaple Union.

WATSON, W., M.R.C.S., has been reappointed Medical Officer of Health to the Rochester Town Council.

WILSON, R. M., M.D., B.Ch. Dubl., has been appointed Honorary Medical Officer to the Derbyshire Hospital for Sick Children.

Vacancies.

For further information regarding each vacancy reference should be made to the advertisement (see Index).

BIRMINGHAM GENERAL DISPENSARY.—Resident Surgeon. Salary, £150 per annum (with an allowance of £30 per annum for cab hire), and furnished rooms, fire, lights, and attendance.

BRADFORD INFIRMARY.—Dispensary Surgeon, unmarried. Salary £100 per annum, with board and residence.

BRADFORD INFIRMARY AND DISPENSARY.—Junior House Surgeon, unmarried. Salary £50 per annum, with board and residence.

BRISTOL ROYAL INFIRMARY.—House Surgeon. Salary £100 a year, with apartments, board, and washing.

CAMBRIDGE LUNATIC ASYLUM, near Cambridge.—Clinical Assistant.

CONVALESCENT HOSPITAL AND SEA-BATHING INFIRMARY, Southport.—Resident Medical Officer. Salary to commence at £150 per annum, with board, lodging, and washing.

DENBIGHSHIRE INFIRMARY AND GENERAL DISPENSARY, Denbigh.—Honorary Medical Officer.

GENERAL INFIRMARY, Birmingham.—Assistant House Surgeon, for six months. Residence, board, and washing provided.

HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST, Brompton.—Resident House Physicians.

HOSPITAL FOR SICK CHILDREN, Great Ormond-street, W.C.—Surgical Registrar, for one year. Honorarium of £40 at the expiration of that term.

HOSPITAL FOR SICK CHILDREN, Great Ormond-street, W.C.—Anæsthetist, for one year. Honorarium of £15 15s. will be voted at the expiration of that term.

HOSPITAL FOR SICK CHILDREN, Great Ormond-street, Bloomsbury, W.C.—Resident Medical Officer for six months. Salary £60, with board and residence. Also House Physician, for six months. Salary £20, with board and residence in the hospital.

KENT COUNTY LUNATIC ASYLUM, Barming Heath, near Maidstone.—Fourth Assistant Medical Officer and Pathologist, for two years (unmarried). Salary £175 per annum (rising £5 a year), with furnished quarters, attendance, coal, gas, garden produce, and washing. Applications to Mr. F. R. Howlett, 9, King-street, Maidstone.

MIDDLESEX HOSPITAL, W.—Assistant Surgeon.

NEW HOSPITAL FOR WOMEN, 144, Euston-road.—Qualified Medical Woman as Pathologist. Also a Clinical Assistant for the Out-patient Department.

NORTH-WEST LONDON HOSPITAL, Kentish Town-road.—Resident Medical Officer and Assistant Resident Medical Officer, for six months. Salary at the rate of £50 per annum attaches to the senior post.

ROTHERHAM HOSPITAL AND DISPENSARY.—Assistant House Surgeon, for six months. Rooms, commons, and washing provided.

ROYAL SOUTH HANTS INFIRMARY, Southampton.—Assistant House Surgeon for six months. £10 will be given at the end of that period if found satisfactory. Board and lodging provided.

ROYAL HOSPITAL FOR DISEASES OF THE CHEST, City-road, E.C.—Resident Medical Officer, for six months. Salary at the rate of £100 per annum, with furnished apartments and board.

ST. LUKE'S HOSPITAL, London, E.C.—Clinical Assistant, for six months. Board and residence provided.

UNIVERSITY OF GLASGOW.—Two Examiners. The appointment will in each case last till Dec. 31st, 1896, at the rate of £50 annually.

WESTERN-SUPER-MARE HOSPITAL AND DISPENSARY.—Medical Officer to the Provident Dispensary attached to the Hospital. Salary £80 per annum, with board, lodging, and washing.

Births, Marriages, and Deaths.

BIRTHS.

BRODIE.—On April 9th, at Chesterfield-street, Mayfair, the wife of Dr. Brodie, of a daughter.

CAMERON.—On April 5th, at 9, Elms-road, Clapham-common, the wife of Albert Cameron, M.B., C.M. Edin., of a son.

CRONK.—On April 4th, at Repton, Derbyshire, the wife of Herbert G. Cronk, M.A., M.B., of a son.

CROOKSHANK.—On April 5th, at Midan Babel Louk, Cairo, the wife of H. E. Crookshank Pacha, F.R.C.S., Director-General of Prisons, of a daughter.

DAVENPORT.—On Feb. 5th, at Chung King, Western China, the wife of C. J. Davenport, F.R.C.S., of the London Missionary Society, of a daughter.

DEVEREUX.—On April 7th, at North House, Tewkesbury, the wife of W. Devereux, M.A., M.B. Cantab., of a daughter.

DIMMOCK.—On April 2nd, at Chatham House, Victoria-avenue, Harrogate, the wife of A. F. Dimmock, M.D., of a son.

RELTON.—On April 6th, at Church-street, Rugby, the wife of Bernard Relton, M.R.C.S., &c., prematurely of a son (stillborn).

REYNOLDS.—On April 8th, at 81, Hornsey Rise, N., the wife of Austin Edward Reynolds, M.R.C.S., L.S.A., of a daughter.

ROLLESTON.—On April 7th, at Upper Wimpole-street, W., the wife of H. D. Rolleston, M.D., F.R.C.P., of a son.

THOMSON.—On April 1st, at Payton-street, Stratford-on-Avon, the wife of Dr. Arthur Thomson, of a daughter.

WARBURTON.—On April 4th, at Langland, Northwood, Rickmansworth, the wife of A. Warburton, M.R.C.S., L.R.C.P., of a son.

MARRIAGE.

ANDERSON STUART—PRIMROSE.—On Sept. 18th, 1894, at Toowoomba, Queensland, Professor Anderson Stuart, University of Sydney, to Dorothy, second daughter of F. A. Primrose, Esq., and granddaughter of the Hon. Bouverie F. Primrose, C.B., Moray-place, Edinburgh, Scotland.

DEATHS.

EARDLEY-WILMOT.—On April 6th, suddenly, Chester Eardley-Wilmot, M.D., B.S. Durh., Senior Assistant Medical Officer at Middlesex County Asylum, near Tooting, in his 28th year.

MEYMOTT.—On April 3rd, at Ludlow, Henry Meymott, M.R.C.S., in his 89th year.

PELLY.—On April 3rd, at Woodstock House, Lee, Kent, Surgeon-General S. M. Pelly, C.B., late Bombay Army, aged 76.

REEKS.—On April 5th, suddenly, at Southwick, Sussex, John Reeks, M.R.C.S., L.S.A., aged 38.

IN MEMORIAM.

BECKETT.—In affectionate remembrance of Henry Arnold Beckett, a true, faithful, and able friend and servant of THE LANCET for nearly forty years, who died on April 11th, 1894, in his 68th year.

N.B.—A fee of 5s. is charged for the Insertion of Notices of Births, Marriages, and Deaths.

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET Office, April 10th, 1895.

Date.	Barometer reduced to Sea Level and 32° F	Direction of Wind.	Dry Bulb	Wet Bulb	Solar Radia in Vacuo	Maximum Temp. Shade	Min. Temp	Rainfall.	Remarks at 8.30 A.M.
April 4	30·09	N.E.	39	38	64	44	38	0·02	Cloudy
" 5	30·24	W.	41	39	76	51	39	...	Cloudy
" 6	29·64	S.W.	45	43	75	51	40	...	Cloudy
" 7	29·30	W.	50	46	62	51	45	...	Cloudy
" 8	29·79	S.W.	45	43	81	57	40	0·07	Overcast
" 9	29·91	S.W.	52	50	105	65	45	...	Overcast
" 10	30·01	S.W.	53	50	103	65	48	...	Cloudy

Notes, Short Comments & Answers to Correspondents.

EDITORIAL NOTICE.

IT is most important that communications relating to the Editorial business of THE LANCET should be addressed *exclusively* "TO THE EDITORS," and not in any case to any gentleman who may be supposed to be connected with the Editorial staff. It is urgently necessary that attention be given to this notice.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

Lectures, original articles, and reports should be written on one side only of the paper.

Letters, whether intended for insertion or for private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

We cannot prescribe or recommend practitioners.

Local papers containing reports or news paragraphs should be marked and addressed "To the Sub-Editor."

Letters relating to the publication, sale and advertising departments of THE LANCET should be addressed "To the Manager."

We cannot undertake to return MSS. not used.

MANAGER'S NOTICE.

UNDER no circumstances do the Proprietors authorise the insertion of loose advertisement circulars and handbills in THE LANCET. Any such announcements are inserted by the newsagents, whom the Proprietors cannot control. At the same time, the Manager will be glad if readers will send him copies of any circulars, with the name and address of the agent through whom they obtain THE LANCET, and the Manager will then endeavour to mitigate the nuisance.

THE LATE MR. J. W. HULKE, F.R.S., P.R.C.S., &c.

MESSRS. BAILLIÈRE, TINDALL, AND COX have sent us a portrait which they have published of the late President of the Royal College of Surgeons of England. The picture has been printed in photogravure by Messrs. Barraud, and is admirable alike as a portrait and as a work of art. Its size, including frame and mount, is 12 in. by 14 in., and the published price is half a guinea. The publishers intend to follow this portrait by a similar one of the late Sir William Savory.

Mr. John W. Gibson.—The General Medical Council take notice of these matters.

"THE BACTERIOLOGICAL TEST OF THE PURITY OF WATER."

To the Editors of THE LANCET.

SIRS,—In the last issue of THE LANCET attention is called (p. 885) to a book by Professor Hankin on the process of testing water for microbes for the use of municipal engineers and others. Can you tell me where this pamphlet is to be obtained?—I am, Sirs, yours faithfully,

A. B. C.

*** The pamphlet in question is printed and published at the "Star Press" Artillery Bazaar, Agra, price 8 annas.—ED. L.

MEDICAL PRACTICE BY TOUTING.

WE append a number of illustrations of this new system. We are deluged with them. The system must soon come under the notice of the examining authorities, whose disciplinary powers should be used for its repression. We shall revert to a more detailed notice of the evil on an early occasion.

DEGENERATION OF MEDICAL METHODS AT CLAPTON, N.E.

WITHIN a very recent period Clapton and Lower Clapton were neighbourhoods where high professional methods were the rule. We trust the following is only an exception proving the rule:—

> "12, Lower Clapton-road (near Clapton-square). Dr. Bremner carries on Practice at the above address. Hours of Consultations: Morning, 9 to 11.30; Evening, 6.30 to 9.30. Fees: Advice with Medicine, from 1s.; Visit with Medicine, 1s. 6d. Midwifery, Vaccination, &c."

We venture to hope that Dr. Bremner has broken the traditions of Clapton without due consideration, and that he will not defend the circulation of such a card as the above.

MEDICAL ADVERTISING AT NOTTING HILL AND THE METROPOLITAN PROVIDENT MEDICAL ASSOCIATION.

WE have had forwarded to us a circular which, we are informed, is placed either under the door or in the letter-box of houses in the neighbourhood. The most prominent features of the bill are the names of "Dr. Bluett," 11, Addison-terrace, W. (registered as M.R.C.S. Eng., L.S.A.), and Dr. Pillow, 1, Pembridge-gardens, W. (registered as L.A.H. Dublin, M.D., M.S. R.U. Ireland). The circular is scattered broadcast, and contains not a syllable of restriction as regards wage-limit or social condition. We appeal to Mr. Bluett and Dr. Pillow to say whether they approve of such methods; and we would appeal to some leaders of the profession who like to encourage thrift whether they sanction this indiscriminate appeal.

A CURIOSITY IN MEDICAL ADVERTISING—A TREBLY QUALIFIED MEDICAL MAN "RUN" BY A DRUGGIST!

ANY description would spoil the following:—

> "Messrs. Briggs and Co., chemists, 65, Battersea Park-road, beg to intimate that a trebly qualified registered practitioner now resides at above address. Charges: Advice and medicine, 1s.; confinement, 10s. 6d.; home visits, 1s.; vaccination; necessary home visits and medicine for a week, 4s. 6d."

It would be interesting to know more of the personality of the modest gentleman who with three qualifications allows himself to be "covered" by druggists.

MEDICAL ADVERTISING AT THE CAPE.

MR. H. WHEATLEY HART, J.P., Cathcart, Cape Colony, asks our opinion on the following card advertisement from the *Farmers' Chronicle* (Cathcart) of Jan. 11th, 1895. The card is indefensible. The profession in the colonies is as dependent as that in the mother country on the traditions of practice and even more so. A door-plate is the only announcement to be commended. We trust Mr. Naugle will on reflection agree with us:—

> "A card.—Dr. E. C. Naugle has commenced practice in Cathcart, and may be consulted at his residence, the cottage lately occupied by Mr. G. J. Taylor, next door to the Standard Bank."

MEDICAL ADVERTISEMENT BY POSTER (20 IN. BY 15 IN.), CAMBERWELL.

THIS is an imposing advertisement. The medical man's name is a conspicuous feature in this bill, and runs as follows;—"Dr. Gallie, 129, Camberwell-road." He is the sole medical officer of the slate club, which "wants" healthy men between seventeen and forty-five, and offers them, besides medical attendance, benefit in sickness, and their families so much at death. Dr. Gallie might be supposed from his description in the Medical Directory to be superior to this kind of thing. He is M.B. Glasg. and C.M., 1882, Member of the British Medical Association, medical officer of Camberwell Provident Dispensary, and surgeon to the P Division of Police. Surely such relations should have restrained Dr. Gallie from consenting to such an unseemly exhibition of his name. If graduates of ancient universities and police surgeons and members of the British Medical Association are to be allowed such licence, what are we to expect in others?

"THE LIQUEFACTION OF HYDROGEN ACCOMPLISHED."

To the Editors of THE LANCET.

SIRS,—A reference to the "Digest," Section 224:4 will refer your readers to an article published in THE LANCET, January 19th, 1878, reporting the liquefaction of oxygen, nitrogen, and hydrogen as one of the greatest discoveries of the year.

I am, Sirs, yours truly,

Boundary-road, N.W., April 6th, 1895. R. NEALE, M.D. Lond.

Justice, a correspondent, points out the frequent appearance of the name and private address of the honorary secretary of the Medical Board, 30, Harcourt-street, Dublin, in the newspaper advertisement of the Meath Hospital and County Dublin Infirmary. The honorary secretary should have his communications addressed to the hospital itself.

THE LATE INSTITUT VIQUERAT.

THE following circular was issued by the Institut Viquerat of Geneva. In spite of the merits of the serum of the ass as a cure for phthisis we learn that the institute has been closed, and that M. Perron, the Geneva banker, who is believed to have found the capital necessary for the undertaking, has acquiesced in the cessation of the manufacture of the fluid.

"HEALING OF CONSUMPTION AND VARIOUS CASES OF TUBERCULOSIS.

"*Discoveries of Dr. Viquerat.*

"Every one knows that consumption has two differents phasis; in the first the tuberculosis bacillus is alone to his destroying work; in the second two others microbes are coming on with the first and hasten the course of sickness, which is then complicated with suppuration. The prepared serum of the ass discovered by Dr. Viquerat cure absoluty tuberculosis, that is no more to argue with the numerous recoveries made. But prepareted ass serum alone cannot overcome consumption in her last phasis, when suppuration and hectic fever have come to complique the trouble. It was then of importance for completing the deed, to add, to ass serum specialle serums appropriated for suppuration. Dr. Viquerat has searched a long time, and, one of thoses serums form his second great discovery. The goat furnish this serum. In November 1894 the Institute had announced that thoses serums would be ready in March 1895; but the preparation has been made a little sooner. The action of thoses serums takes soon away the hectic fever and suppuration. It ensue (this dreadful complication no more existing) that the physician has only the single tuberculosis to heal. And, it is now known that the prepared serum of asses; heal perfectly tuberculosis in some months. Then, with thoses discoveries, all no-cachetic consumptives who have sufficiently healthy lungs to subsist could revive to health, but, one must understand, that science cannot do more: make again organs that have disappeared. To heal every sickness, organism shall offer sufficiently power to help the struggle against the trouble. All persons troubled with weak chest, all kind of tuberculosis, and the consumptives who wishes to place themselves under the medical treatment of the Institute, will be able to do so by coming to Geneva for the length of the cure. They will be able to settle in the numerous hotels or boardinghouses in the town, and can be attended at their lodgings, when momentarily unable to come to the Institute. The price of the medical treatment is 350 f. monthly. The Institute having momentarily a relatively little quantity of anti-suppurative serum, the patients affected with suppuration and hectic fever, shall register themselves as soon as possible. They will be treated in the range of inscription. Please send with the registry a cheque or postal order of 25. frs, it will be worth on the treatment price. The registry is unnecessary for the patients who have single tuberculosis, the Institute having enough anti-tuberculous serum for all demands. Patients are advised that Dr. Viquerat occupies itself exclusively of the laboratory works and that the treatment in the Institute is placed under the direction of the clinik chief physician M. Dr. Jacot. All what concerns the Viquerat's Institute shall be addressed to Mr. Ch Perron.

"Ch. PERRON,
"Director of Viquerat's Institute.

"Côte-Drize, Geneva, 25 January 1895."

Mr. H.—We never depart from our rules in these matters. We can neither recommend individual practitioners nor suggest treatment.

A WARNING.

To the Editors of THE LANCET.

SIRS,—A tall fair woman, stating she is a Russian and destitute, is calling round the neighbourhood of Harley-street complaining that a medical man of whom she has begged for some time will not give her any more money. He has helped her on several occasions, but on having a report from the Charity Organisation Society declined further assistance, and has placed the matter into the hands of his solicitor, Mr. Robert Todd, of 1, York-buildings, Adelphi, who would like to hear from anyone to whom she may apply. I write this to put the members of the profession on their guard. I am, Sirs, yours truly,

April 9th, 1895. M.D.

WANTED, A HOME.

To the Editors of THE LANCET.

SIRS,—Can you or any of your numerous readers inform me of a home where the sons of a deceased medical man, who has left no provision for them, can be taken in free, or with very small premium?

I am, Sirs, yours faithfully,

April 10th, 1895. J. N.

J. C. B.—There may be some business or legal reason for the advertisement sent us for which the parties to it are not responsible. We do not feel called on to comment upon it.

L.S.A.—Our correspondent is at liberty to describe himself on his door-plate as "Physician and Surgeon," whether he does so or not being a matter of taste. His neighbour is clearly wrong in prefixing "Dr." to his name.

THE CASE OF MR. C. BRYAN TOWNSHEND.

THE following donations have been received in addition to those already announced and are hereby thankfully acknowledged:—

Dr. G. Fielding Blandford	£1	1	0	Dr. George Macdonald (London)	£3	3	0
A "Sympathiser," per Dr. V. Dickenson (London)	3	3	0	Dr. James Black (London)	0	10	0
Dr. E. W. Emtage (Holsworthy)	0	5	0	Dr. P. G. Burghard (London)	1	1	0
Dr. A. Watson (London)	0	5	0	Dr. E. Nettleship	3	3	0
Dr. T. Morton (Kilburn)	1	1	0	Dr. W. H. Fenton	2	2	0
Dr. C. W. Chapman (London)	1	1	0	Dr. Wharton P. Hood	5	0	0
P. G.	0	10	0	Dr. Cheadle	2	2	0
E. E.	0	10	6	Dr. G. Anderson Critchett	2	2	0
Dr. W. T. O'Grady (Swinton)	1	1	0	Dr. William Hunter (London)	1	1	0
Dr. R. Paramore (London)	0	10	6	Dr. Woodhouse Braine	2	2	0
Sir Henry Thompson	3	3	0	Dr. R. B. Townsend (Oxford)	1	0	0
Dr. C. A. Ballance	2	2	0	Dr. W. P. Herringham (London)	1	1	0
Dr. Cullingworth	1	1	0	Dr. Pearce Gould	3	3	0
Dr. E. Clifford Beale	1	1	0	P. G.	0	10	0
Dr. Ed. Liveing (London)	1	1	0				

Further donations are earnestly invited by the Rev. H. Townshend, 41, King Henry's-road, South Hampstead, N.W.

Inquirer.—It is now necessary for a practitioner who desires to practise in France and possesses English degrees or licences to pass at least the two final examinations required for the French M.D. degree. For this a knowledge of French is indispensable. The old diploma of Officier de Santé, which at one time was commonly taken by English practitioners, is now abolished.

Cedric has omitted to supply us with his name and address.

RUPTURE OF THE QUADRICEPS EXTENSOR TENDON.

To the Editors of THE LANCET.

SIRS,—I was called at 11 P.M. on the 22nd ult. to a postman who was said to have injured his knee. On his way home after a long day's work he stumbled when about a quarter of a mile from his house, and in endeavouring to check himself from falling backwards he heard a distinct snap and felt a sharp pain above his right knee-joint. With great difficulty he hobbled home. On examination I found the patella intact, but abnormally movable. The upper border of the bone was sharply defined, and above it was a distinct gap, in which subcutaneous ecchymosis was evident. In this region there was dull aching increased by pressure. There was total inability to extend the right leg. Mr. Kirkpatrick, who saw the case next day, agreed in my diagnosis of rupture of the quadriceps extensor. As this accident appears to be rare, we thought it might interest the readers of THE LANCET. The patient thinks that the tendon was weakened by his former occupation of shoemaking, in which there is constant hammering over the region in question. It would be interesting to hear of recent similar cases in hospital practice and what treatment has been found successful. The patient in question is sixty-two years of age, healthy and active.

I am, Sirs, yours faithfully,

Woodbridge, April 1st, 1895. EDWARD C. B. IBOTSON, L.S.A.Lond.

*** When a violent contraction is made by the quadriceps extensor muscle of the thigh in order to avert a fall any one of four lesions may occur. By far the commonest is a transverse fracture of the patella, and this is especially likely to happen if the knee is flexed. Very rarely it happens that the ligamentum patellæ or the tendon of the quadriceps extensor gives way, and these two lesions seem to occur with almost equal frequency. But rarer still is rupture of the substance of the muscle itself; for Delon was able to collect thirty-six cases of rupture of the tendon of the quadriceps, but only six cases of rupture of the muscle. The above case is an interesting example of rupture of the quadriceps tendon. The treatment of this condition merely by rest and splints gives very fair results and useful limbs; but with due antiseptic precautions a more energetic treatment may sometimes be adopted, for Chaput in 1889 sutured the ruptured tendon in one case with a perfectly satisfactory result (Société de Chirurgie, Paris, December, 1889).—ED. L.

A QUESTION OF FEE.

To the Editors of THE LANCET.

SIRS,—What could be considered a reasonable fee to charge the Rural District Council for each visit to the isolation tents, which are a mile and a half from my residence? I am, Sirs, yours truly,

INQUIRER.

*** Without further particulars it is a little difficult to answer our correspondent's question as precisely as we could wish. Assuming, however, as we do, that the arrangement proposed is to be a special and temporary one, and that our correspondent is to advise as to the general control of the camp, we think a fee of one guinea per day, to include, if necessary, more than one visit, would be a fair remuneration.—ED. L.

HILL'S PATENT EGG-CUP.

AN ingenious novelty in culinary appliances has been forwarded to us by the Premier Egg-Cup Co., 22, Imperial-buildings, Ludgate-circus, E.C. It resembles a deep, rather narrow porcelain tea-cup without a handle, having a German silver lid, which screws on. The raw egg is cracked and the contents turned neatly into this cup; then the lid is securely fixed, and the whole boiled just as if it were an egg in the shell, but for a minute or two longer than the usual time. The cup can be lifted out of the water with wire tongs, and after being wiped is sent to table unopened. The lid being then unscrewed, the contents are eaten just as out of the natural shell. A practical trial has fully justified the description given by the vendors, an egg cooked in this way being equal to an ordinary boiled egg, and free from the wateriness and loose texture of a poached egg. An obvious advantage is that the cook can make sure of the soundness of an egg before sending it to table, and two or more small eggs may be conveniently combined in one of the larger sizes of cup.

C. B. M. S.—We see nothing to object to in the arrangement suggested. It is certainly true that there is much need of instruction in the elements of good home nursing; and it cannot be given more carefully or with more precaution against abuse than by a medical man.

PRACTICE IN NEW ENGLAND.

To the Editors of THE LANCET.

SIRS,—Can any of your readers say what chances a Scotch graduate would have for medical practice in the New England States of North America if he were to go out there? Information through your columns will be gratefully received.—I am, Sirs, yours faithfully,

April 9th, 1895. X. Y. Z.

*** In our opinion a Scotch graduate would have no obvious claim on the attention of the public in these particular States. America is well supplied with universities, ranging from the very good to the very bad, all of which give the title of M.D. to their students, while the New England States are by geography likely to attract the graduates of the Canadian Universities also.—ED. L.

COMMUNICATIONS not noticed in our present issue will receive attention in our next.

Medical Diary for the ensuing Week.

OPERATIONS.

METROPOLITAN HOSPITALS.

MONDAY.—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), St. George's (1 P.M.), St. Mark's (2 P.M.), Chelsea (2 P.M.), Samaritan (Gynecological, by Physicians, 2 P.M.), Soho-square (2 P.M.), Royal Orthopædic (2 P.M.), City Orthopædic (4 P.M.).

TUESDAY.—London (2 P.M.), St. Bartholomew's (1.30 P.M.), Guy's (1.30 P.M.), St. Thomas's (3.30 P.M.), Westminster (2 P.M.), West London (2.30 P.M.), University College (2 P.M.), St. George's (1 P.M.), St. Mary's (1.30 P.M.), St. Mark's (2.30 P.M.), Cancer (2 P.M.), Gt. Northern Central (2.30 P.M.).

WEDNESDAY.—St. Bartholomew's (1.30 P.M.), University College (2 P.M.), Royal Free (2 P.M.), Middlesex (1.30 P.M.), Charing-cross (3 P.M.), St. Thomas's (2 P.M.), London (2 P.M.), King's College (2 P.M.), National Orthopædic (10 A.M.), St. Peter's (2 P.M.), Samaritan (2.30 P.M.), Gt. Ormond-street (9.30 A.M.).

THURSDAY.—St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), University College (2 P.M.), Charing-cross (3 P.M.), St. George's (1 P.M.), London (2 P.M.), King's College (2 P.M.), Middlesex (2 P.M.), Soho-square (2 P.M.), North West London (2 P.M.).

FRIDAY.—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), Guy's (1.30 P.M.), Charing-cross (3 P.M.), St. George's (1 P.M.), King's College (2 P.M.), Cancer (2 P.M.), Chelsea (2 P.M.), Gt. Northern Central (2.30 P.M.).

SATURDAY.—Royal Free (9 A.M. and 2 P.M.), Middlesex (1.30 P.M.), St. Thomas's (2 P.M.), London (2 P.M.), University College (9.15 A.M.), Charing-cross (3 P.M.), St. George's (1 P.M.), Cancer (2 P.M.).

At the Royal Eye Hospital (2 P.M.), the Royal London Ophthalmic (10 A.M.), the Royal Westminster Ophthalmic (1.30 P.M.), and the Central London Ophthalmic Hospitals operations are performed daily.

SOCIETIES.

WEDNESDAY.—ROYAL METEOROLOGICAL SOCIETY (25, Gt. George-st., Westminster).—7.30 P.M. Mr. F. Campbell Bayard and Mr. William Marriott: The Frost of January and February, 1895, over the British Isles.—Mr. Birt Acres: Some Hints on Photographing Clouds.

ROYAL MICROSCOPICAL SOCIETY (20, Hanover-sq., W.).—8 P.M. Mr. A. D. Michael: On the Form and Proportion of the Brain in the Oribatidde and in some other Acarina.

NORTH-WEST LONDON CLINICAL SOCIETY.—8.30 P.M. Clinical Evening.

THURSDAY.—HARVEIAN SOCIETY.—8.30 P.M. Clinical Cases. Dr. Alexander Morrison: On Syncopal Brady Cardia.

Communications, Letters &c. have been received from—

A.—Mr. J. W. Alexander, Rainhill; Anderson's Coll. Med. School, Glasgow, Sec. of.

B.—Dr. A. Bronner, Bradford; Mr. J. Barclay, Glasgow; Mr. T. B. Browne, Lond.; Mr. D. Biddle, Kingston-on-Thames; Mr. T. H. Benson, Lond.; Mr. C. Birchall, Liverpool; Miss E. Beckett, Lond.; Messrs. Blondeau et Cie., Lond.; Birmingham Gen. Hosp., House Governor of; *Birmingham Daily Post*, Publisher of; Bristol Roy. Infy., Sec. of; Bradford Infy., Sec. of; Beta.

C.—Dr. O. Carit, San José, Costa Rica; Brig.-Surg.-Lieut.-Col. W. Hill Climo, Lond.; Mrs. A. Chapman, Lond.; Messrs. F. Comar and Son, Lond.; Messrs. Condy and Mitchell, Lond.; Messrs. J. and A. Churchill, Lond.; County Asyl., Dorset, Med. Supt. of; Cripples' Nursery, Lond., Lady Supt. of; C., Lond.

D.—Mr. G. Duncan, Berlin; Mr. E. De Sinner, Lond.; Dr. D. L. Davies, Criccieth, Carnarvonshire; Messrs. W. Dawson and Sons, Lond.; Messrs. Dakin Bros., Lond.; Demonstrators of Anatomy, Edinburgh; D. M., Leeds.

E.—Mr. F. R. L. Edwards, Manchester; Mr. E. F. Eliot, Southampton; Examinations, Lond.

F.—Dr. R. W. Felkin, Edinburgh; Mr. W. B. Forbes, Lond.; Fulbourn County Asyl., Clerk of; Fortes, Lond.; Forceps, Liverpool.

G.—Dr. G. C. Garratt, Lond.; Mr. J. Greenway, Southport; Mr. J. Gay, Lond.; Mr. S. A. E. Griffiths, Lond.; Messrs. R. W. Greeff and Co., Lond.

H.—Dr. G. Herschell, Lond.; Dr. F. Hawkins, Reading; Mr. J. Hutchinson, Lond.; Mr. W. H. Haley, Lond.; Mr. A. Haviland, Douglas; Mr. J. Heywood, Manchester; Haskin Wood Vulcanising Co., Lond.

J.—Dr. H. Jones, Lond.; Dr. P. P. Jennings, Tonypandy; Dr. W. O. Jennings, Paris; Mr. H. K. Johnstone, Margate; Mr. J. G. Jefferson, Lisburn.

K.—Dr. H. R. Kenwood, Lond.; Mr. C. B. Keetley, Lond.; Mr. R. V. Ker, Dundee; Messrs. Krohne and Sesemann, Lond.; Kensington Hosp. for Women, Sec. of.

L.—Dr. J. F. Little, Lond.; Mr. J. B. Lamb, Lond.; Mr. S. C. Lawrence, Tilt Cove, Newfoundland; Mr. T. Laffan, Cashel; Mr. B. Lord, Manchester; Mr. R. C. Lucas, Lond.; Messrs. Lucius and Brüning, Lond.

M.—Dr. W. Marcet, Lond.; Dr. J. D. Malcolm, Lond.; Dr. J. B. Maurice, Marlborough; Mr. R. Mosse, Lond.; Mr. F. Marshall, Lond.; Mr. W. Macphail, Lond.; Mr. A. Mulliner, Northampton; Mr. J. Moir, Leytonstone; Messrs. Mather and Crowther, Lond.; Messrs. Macmillan and Co., Lond.; Messrs. E. Macfee and Co., Lond.; Maltine Manufg. Co., Lond.; M.D., Addison-gardens.

N.—Mr. A. Neve, Kashmir.

O.—Mr. J. Oliver, Lond.

P.—Dr. S. R. Philipps, Virginia Water; Mr. A. L. Phillips, Salisbury; Mr. Y. J. Pentland, Edinburgh; Mr. F. T. Paul, Liverpool; Messrs. Parke, Davis, and Co., Lond.

R.—Mr. F. J. Reilly, Lond.; Mr. A. Roche, Dublin.

S.—Dr. J. A. Shaw-Mackenzie, Lond.; Dr. F. H. Simmons, Johannesburg; Mr. W. Seargill, Colchester; Mr. J. B. Smith, Lond.; Messrs. Street Bros. Lond.; Messrs. Stubbs, Bradford; Messrs. G. Street and Co., Lond.; Messrs. Stubbs, Landport; Standard Malt Extract Co., Lond.; Society for the Prevention of Hydrophobia, Enfield, Hon. Sec. of; Sanitary Committee, Truro, Sec. of.

T.—Dr. F. Tresilian, Lond.; Dr. H. C. Thompson, Osborne; Dr. C. B. Taylor, Nottingham; Mr. J. Thin, Edinburgh; Surg.-Lieut. R. G. Turner, Afghan, India; Rev. A. Tooth, Croydon.

W.—Dr. C. T. Williams, Lond.; Mr. C. B. Willacy, Liverpool; Mr. S. Wand, Leicester; Mr. L. D. Ware, Camborne; Mr. J. R. Whitaker, Edinburgh; Messrs. J. Wright and Co., Bristol; Weston-super-Mare Hosp., Hon. Sec. of.

Letters, each with enclosure, are also acknowledged from—

A.—A. B. Z., Lond.

B.—Mr. J. H. Booth, Chesterfield; Mr. E. G. Byrne, Cardiff; Capt. F. Beauclerk, Lond.; Beaufort, Lond.; Butterworth, Lond.

C.—Dr. A. Cameron, Lond.; Dr. E. N. Carless, Devizes; Mr. J. Carter, Lond.; Mr. L. Cooke, Aspull; Crown Accident Insurance Co., Bristol, Sec. of; Cumberland, Liverpool; Claret, Lond.; Conifer, Lond.; C., Lond.

D.—Dr. Davidson, Hull; Dr. W. Dale, Truro; Dr. N. B. Daralisett, Upper Chindwin, Burmah; Dr. E. M. De Souza, Bombay; Mr. H. A. Dickson, Lond.; Messrs. Deacon and Co. Lond.; Delta, Lond.; D. M., Leeds; D.

E.—Experienced, Lond.

F.—Dr. Forsayeth, Attleborough; Mr. H. Freeman, Lond.; Mr. R. Fitzgerald, Midleton, co. Cork.

H.—Mr. F. Howse, Rotherham; Mr. W. Halley, Lond.; Mr. J. B. Husley, Brighton; Hotspur, Lond.

J.—Dr. W. Jamison, Belfast; Mr. Y. M. Jones-Humphreys, Cemmaes.

K.—Dr. C. B. Ker, Glasgow.

L.—Mr. S. C. Lawrence, Tilt Cove, Newfoundland; Mr. R. A. B. Lowry, Londonderry; L., Ashford.

M.—Dr. G. A. Mason, Lond.; Dr. Y. McClure, Chesterfield; Dr. J. McNaught, Manchester; Dr. F. C. MacNalty, Winchester; Mr. McLeod, Edinburgh; Mrs. Maunsell, Lond.; Messrs. F. G. Moore and Co., Lond.; Marlborough-road, No. 7, Bradford; M.R.C.S., Lond.

N.—Mr. C. W. Nixon, Sheffield.

P.—Mr. L. W. Powell, Bristol; Principal, Broadstairs; P. S. E., Lond.

R.—Dr. F. C. Rebello, Bahia; Mr. R. Roberts, Ludlow; Mr. W. M. Riley, Hereford; Mr. W. B. Rotherve, Lond.; Mr. A. E. Reynolds, Lond.; Mr. F. J. Reilly, Lond.; Messrs. Richardson Bros. and Co., Liverpool.

S.—Dr. B. R. Sawnby, Rawalpindi; Dr. A. Stuart, Sydney, N.S.W.; Mr. F. Scorea, Southwick; Mr. C. F. Sutton, Holmes Chapel; Messrs. Stubbs, Lond.; Sarbach's News Exchange, Mainz; Statim, Lond.; Scalpel, Lond.; Surgeon, Douglas; Salis, Lond.

T.—Mrs. E. Tough, Lond.; Theta, Newcastle-on-Tyne.

U.—Urbanus, Lond.; Urgent, Lond.

V.—Viator, Lond.

W.—Dr. W. H. Williams, Dwyran; Mr. H. J. L. Wales, Oundle; Mr. G. C. Wills, Bath; Mr. A. Willson, Sheffield.

X.—X. Y. Z., Lond.

During the week marked copies of the following newspapers have been received:—*Andover Advertiser, Northern Echo, Newcastle Chronicle, Boston Independent, Birmingham Post, Bradford Observer, Manchester Guardian, Derbyshire Advertiser, North Middlesex Chronicle, South-Eastern Gazette, Sussex Daily News, Hertford Chronicle, Bedfordshire Mercury, Scarborough Post, Stockton Herald, Craven Herald, New York Herald, Glasgow Bailie, Lisburn Standard, Bristol Mercury, Sanitary Record, Leeds Mercury, Lincolnshire Chronicle, Yorkshire Post, Hertfordshire Mercury, City Press, Weekly Free Press and Aberdeen Herald, Liverpool Daily Post, Times of India, Builder, Pioneer Mail, Reading Mercury, News, Architect, Local Government Chronicle, West Middlesex Standard, Mining Journal, Surrey Advertiser, Guy's Hospital Gazette, Natal Witness, Local Government Journal, West Middlesex Advertiser, Brechin Advertiser, Berwickshire News, Citizen, Scotsman, Kelso Mail, Falkirk Herald, Invergorden Times, Kentish Mercury, Bridgwater Mercury, Tenby Observer, Carlisle Journal, Royal Cornwall Gazette, Somerset City Herald, Croydon Guardian, Surrey Times, Cork Constitution, Medical Record, New York, Islington Gazette, Chester Courant, &c., &c.*

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